The Modern Hospital

JUNE 1957

DISASTER DEMONSTRATION AT FAIRVIEW PARK HOSPITAL, CLEVELAND (PAGE 85)

The Hospital Spendthrift . . .
and you're paying the bill!

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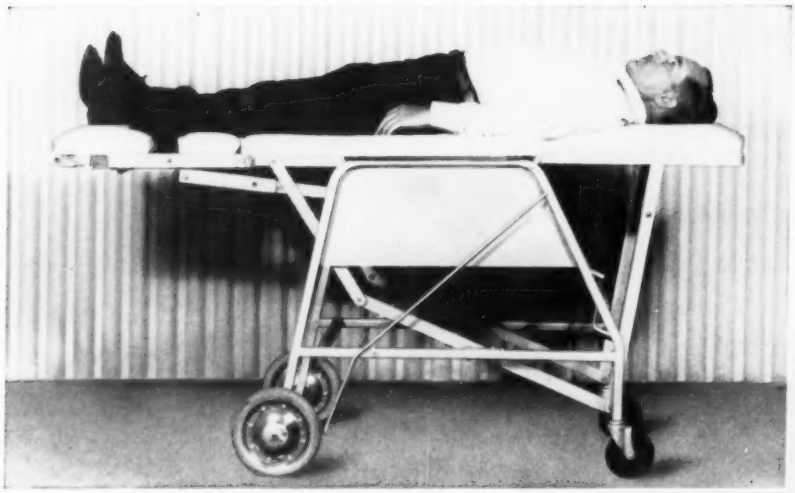

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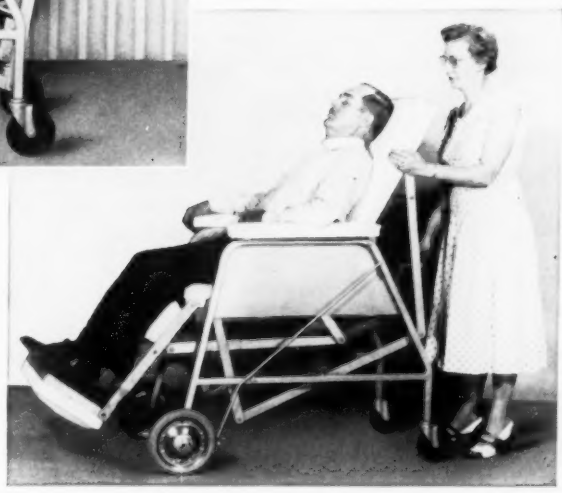

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The Modern Hospital

JUNE 1957

VOLUME 88, NO. 6

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AMONG THE AUTHORS

Dr. Robert S. Myers and Dr. Vergil N. Slee

Dr. Robert S. Myers, whose article describing the new medical audit procedure developed by the Commission on Professional and Hospital Activities, Inc., appears on page 57, is assistant director of the American College of Surgeons and treasurer of the Commission. A graduate of the Harvard Medical School, Dr. Myers served a residency in surgery at the Peter Bent Brigham Hospital in Boston and practiced surgery there before joining the staff of the College. He is a fellow of the American College of Surgeons and is the author of many articles on medical audit procedure and medical staff organization that have appeared in The MODERN HOSPITAL and other journals. **Dr. Vergil N. Slee,** co-author with Dr. Myers of the article on medical audit procedure, is director of the Commission on Professional and Hospital Activities, an outgrowth of the Professional Activities Study of the Southwestern Michigan Hospital Council. As administrator of the Barry County Health Center, Hastings, Mich., Dr. Slee directed the council's study. He is a graduate of Washington University Medical School, St. Louis, and is certified by the American Board of Preventive Medicine.

Donald M. Rosenberger

Alonzo Clark

Eight years of work transformed an idea and three hospitals into the Maine Medical Center, Portland, the Modern Hospital of the Month. On page 79, **Alonzo Clark,** architect, and **Donald M. Rosenberger,** administrator, describe the steps taken to combine Maine General Hospital, Children's Hospital, and Maine Eye and Ear Infirmary General into the center. Mr. Clark is associated with Voorhees Walker Smith & Smith, New York architects. He is a member of the American Institute of Architects' committee on hospitals and health and chairman of his regional committee, as well as a consultant in hospital design to the army surgeon general. Before going to Maine General Hospital in 1949, Mr. Rosenberger was director of Hamot Hospital, Erie, Pa., for eight years. He is a member of the American College of Hospital Administrators.

Dr. Seward E. Owen

Edmund P. Finch

The correlation of clinical laboratory staff and diagnostic tests performed involves many factors. **Dr. Seward E. Owen** and **Edmund P. Finch** found that many circumstances may affect the work output. The operation study methods they devised (*p.* 102) have been useful in assigning staff, estimating work load requirements, and determining laboratory budgets at the Veterans Administration Hospital, Hines, Ill. Dr. Owen is chief of the laboratory section, laboratory service, at the hospital. Author of more than 40 scientific papers and a former associate professor of physiology at the University of Utah, Dr. Owen has served with the V.A. since 1933. Mr. Finch is biochemist and supervisor of the main clinical laboratory at the Hines hospital. During World War II he served as a laboratory officer at hospitals in Pennsylvania and Puerto Rico.

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ROVING REPORTER

MacEachern Portrait Copied

Our hospital has obtained a negative of the portrait of the late Dr. Malcolm T. MacEachern. We had a photographer enlarge it, and it is now hanging in our reception room, where it has received many favorable comments. The receptionist has received a great many inquiries from visitors about Dr. MacEachern's life and the portrait.

The original portrait was unveiled at the American Hospital Association meeting in September 1955, only a few months before Dr. MacEachern's death.

Our photographic reproduction is in sepia. It cost us about $30 to have the work done, excluding the frame and the bronze plaque. Of course, the original photograph of the color portrait was made by the American College of Hospital Administrators, and we imposed on them to lend us the negative to make our picture.—A. A. AITA, *administrator, San Antonio Community Hospital, Upland, Calif.*

Portrait of the late Dr. Malcolm T. MacEachern made from the photographic negative of original painting.

Play Rug Charms Children

For years hospitals have been wrestling with the problem of what to do with the youngsters who come along with their mothers to week-day clinics. If left to their own devices, the children are likely to run through corridors, slide down the banisters, open doors to examining rooms, and so on.

Lenox Hill Hospital, New York, has found a way to solve the problem. In the pediatric clinic, it has put down a play rug, loaded with toys, to divert the attention of youngsters while their mothers are busy elsewhere with another child in the family.

Faith Ault and Nancy Adams, trained

A little help from a friendly volunteer, an absorbing game, and a large play rug keep children happy at the Lenox Hill Hospital pediatric clinic, New York.

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volunteers, supervise the playroom and handle distribution of toys, arbitration of disputes, and trips to the lavatory. Doctors near by can be called on if necessary in a particular situation. The project is under the direction of Mrs. Oliver F. Wadsworth, president of the women's auxiliary of Lenox Hill Hospital.

Kentucky Recruits Students

In Kentucky, the state hospital association is doing something about recruitment of nurses. For the last four years the association has conducted an essay contest for juniors and seniors in the state's high schools.

The association is divided into four conferences, and a local committee judges the best essay in each area. These four essays are then rated by a state committee. Each year 100 or 150 compositions are entered, and each girl is asked to state her choice of nursing school in the state. Following the state convention, every school is given the names and addresses of the girls who expressed interest in its training program. The schools then follow up with letters. The percentage of students obtained in this way is not known, but school directors believe the contest is most worth while.

Scholarships are arranged with the school the winner prefers, and additional scholarships have been obtained in some instances for nonwinners who are interested in nursing but who cannot finance the course. Nazareth College gives a four-year scholarship to its collegiate school of nursing and now has three students enrolled through the contest, including this year's winner. The first year's winner has been graduated from Norton Memorial Infirmary in Louisville, and is now an assistant head nurse.

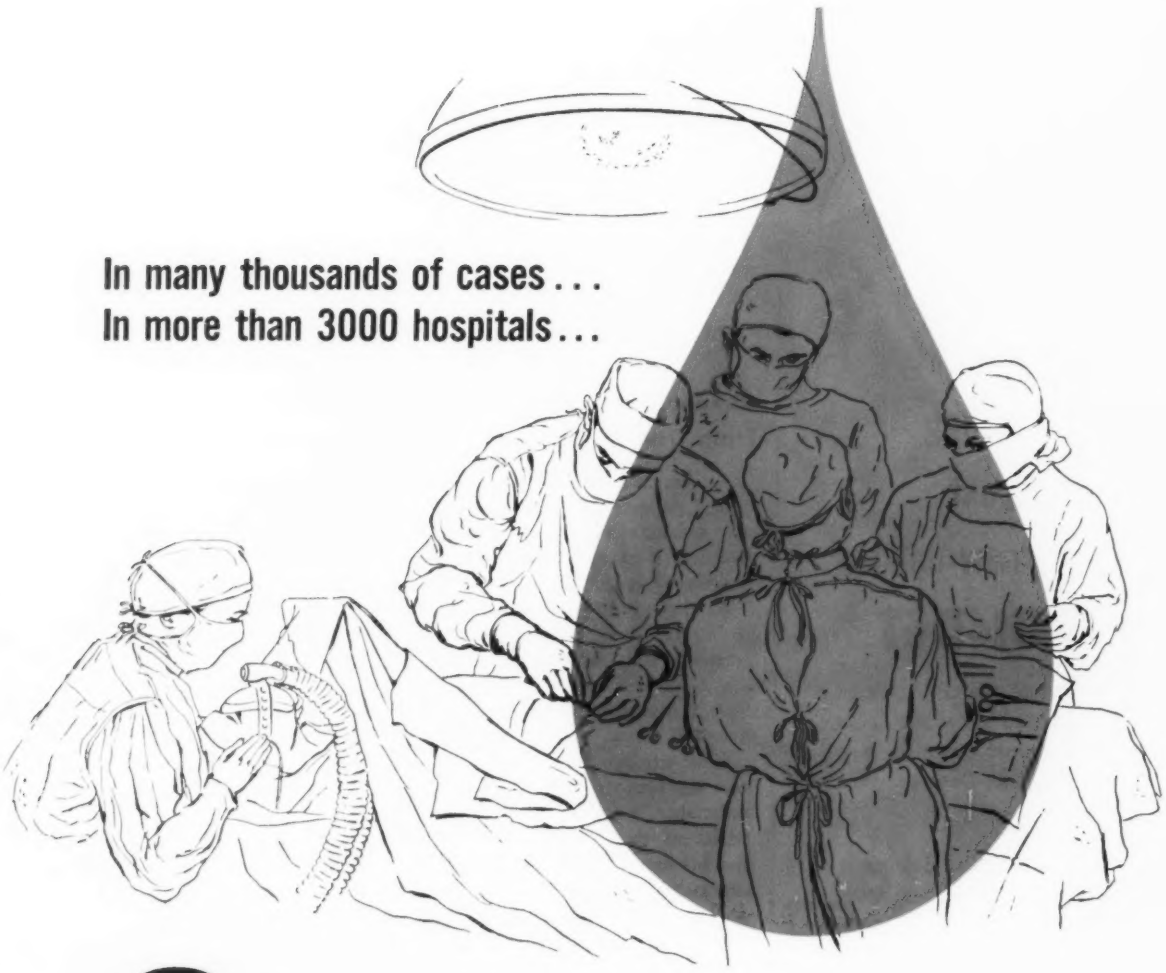
Each of the four conferences gives a $25 savings bond, plus a trip to the convention to its winner. Top prize from the association is a $100 bond, with a $50 bond as second prize.

The hospital association has tried two methods to promote interest in communities. Originally entry blanks were sent to all hospital administrators in the state, and each communicated with the high schools in his area. This year, entry blanks and posters were sent directly to the high schools. However, the first method gives the administrator a chance to talk directly with the principal or counselor, awakening more direct interest in the contest and promoting good relationships between the hospital and the school. Next year, we probably shall try the first method, or a combination of the two.

This year's winner, in discussing "Why I Choose a Nursing Career," said, in part:

"Always I have had this desire to cheer the miserable, to relieve suffering. Then I began to read about those who did. These stories were full of sacrifice on a high and noble plane. I know I will perform my services in a different setting. Usually I will find clean surroundings in place of filth and vermin, knowledge replacing ignorance, many supplies, and much assistance. Would my service be less rewarding in its spiritual satisfaction? I had to learn about nursing as it is today. To do this I listened to the interchange of day-to-day experience between my mother, a nurse, and those who work with her.

"How I laughed to hear their account of the indulgent mother who tried to sneak her little boy's dog into the hospital 'just to keep Tommy company.' Tears stung my eyes as I learned of the grief-stricken young husband,



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married just a year, whose wife died in childbirth; of the cancer patient who would never get well. I learned that joy, too, can be found in a hospital ward. It shines from the eyes of a little boy, born without legs, who has just received his first set of artificial ones; in the tender gaze of a mother upon her new-born babe.

"Throughout all, the nurse stands ready to give help where help is needed, comforting each sorrow, sharing each joy, lending, if only by her presence, a dignity to each.

"It is with a combination of humility and confidence that I am approaching a nursing career, humility because I am only human and know I shall make mistakes, confidence because I have put my faith in a power greater than that of any human being."—ELIZABETH D. SIMMERMAN, *executive secretary, Kentucky Hospital Association.*

Auxiliary Learns How a Hospital Works From Dramatized Case History of Patient

A dramatized case history of a typical patient has given members of the women's auxiliary of Evanston Hospital, Evanston, Ill., a new understanding of hospital procedures.

At the auxiliary's annual meeting, an "all-star" cast of Evanston Hospital personnel discussed a case history that might be familiar to any family. The former administrator of the hospital, Arkell B. Cook, played the rôle of a patient stricken with a heart attack, who was brought to the hospital in an ambulance. In panel form, the dramatization of the patient's hospital stay and his eventual release for home recuperation presented the work of each department that helped the patient.

Emergency treatment was outlined by the chief of the department of medicine, Dr. Leonard F. Jourdonais, who portrayed the patient's physician. The tactful help of the staff nurse, Marilyn Kruse, in restoring the security of the suddenly immobilized patient was described. Goldie Pugh, the social service director, explained her rôle in helping the patient's wife meet the problems she must face. Alice Duane, visiting nurse, discussed how she worked with the patient and his family as they adjusted to his physical and psychological needs during home recuperation.

Mrs. A. K. Randolph, auxiliary member who planned the program, portrayed the patient's wife and also acted as moderator for the panel.

The panel demonstrated how, throughout the whole period of hospitalization and recuperation, the patient was treated as an individual by a professional group informed in all aspects of his physical and psychological condition.

In a question and answer period following the panel discussion, auxiliary members learned that patients will receive immediate care in the hospital's emergency department in the case of sudden illness or accident, even though their personal physician may not be affiliated at Evanston Hospital; that the patient is treated regardless of whether he has insurance or is in a position to pay, and that the question of payment is routine only after the patient's condition is determined and the necessary care provided.—LAURA HOFFMAN, *women's auxiliary, Evanston Hospital Association, Evanston, Ill.*

On stage in Evanston Hospital, Evanston, Ill., are panelists who dramatized a typical case history to show women's auxiliary members how the whole hospital is involved in the care of a patient. Left to right are: Mrs. A. K. Randolph, former chairman of the auxiliary's nursing committee; Arkell B. Cook, former administrator of the hospital; Dr. L. F. Jourdonais, chief, department of medicine; Goldie Pugh, social service director; Marilyn Kruse and Alice Duane, nursing.

Face Bad News for Good Health in Public Relations

By GORDON DAVIS

Gordon Davis

THE case history this month concerns a familiar, forlorn and reluctant subject: the man who suspects he has something wrong with his innards and is scared to death of finding out just what.

In hospitals and doctors' offices he is that tragic figure, the chronic or terminal case whose folly has at last caught up with him. Under less severe circumstances he is the miserable soul who, in confidential moments, admits alarming symptoms but steadfastly declines a doctor's help.

Be sympathetic. These unfortunates aren't strangers; they're us. Human nature—yea, even our own—shrinks instinctively from bad news except, of course, when it involves someone else.

And therein lies the substance of a lesson in public relations.

Like the maintenance of good health, the conduct of good public relations involves realistic appraisal of the possibility of bad news. It makes use of systematic critical reexamination as determined as the most searching physical, for the public relations health of any organization or institution is far too important to be left to chance.

Almost anyone who ponders the matter will agree with these statements. They are largely obvious. Yet it is equally obvious that many organizations are either uninterested in establishing the true status of their public relationships or are genuinely fearful of doing so. I give you, by way of illustration, the suspicion, apprehension and neglect commonly accorded one of the most useful public relations instruments devised by modern social science: the attitude study or opinion survey.

Some critics hold that opinion studies aren't accurate. Some consider them "unnecessary." Some are afraid they will encourage criticism. Some render them impotent by slanting or emasculation. Some treat the whole idea with indifference or even contempt.

Let no one mislead you in any of these directions. Our biggest commercial enterprises depend for competitive survival on the results of market and audience research. Multimillion dollar advertising campaigns trace their origins directly to such studies. The costliest radio and television programs rise and fall by their findings. New products, from automobiles to pancake mixes, are not even committed to engineering departments or laboratories until there has been objective analysis of public wants and tastes, public antipathies and dissatisfactions.

To decline to study your public relations audiences by convenient and established social research methods is like rejecting the use of x-ray and laboratory in medical diagnosis. In both cases you can get by through the generous use of intuition, experience and common sense—at least for as long as the patient's symptoms are reasonably visible.

But beware the insidious or incipient malady! Beware the human instinct to reject the possibility of personal bad news! In today's complex society, audience temper often is buried well beyond the capacity of our unaided senses to probe.

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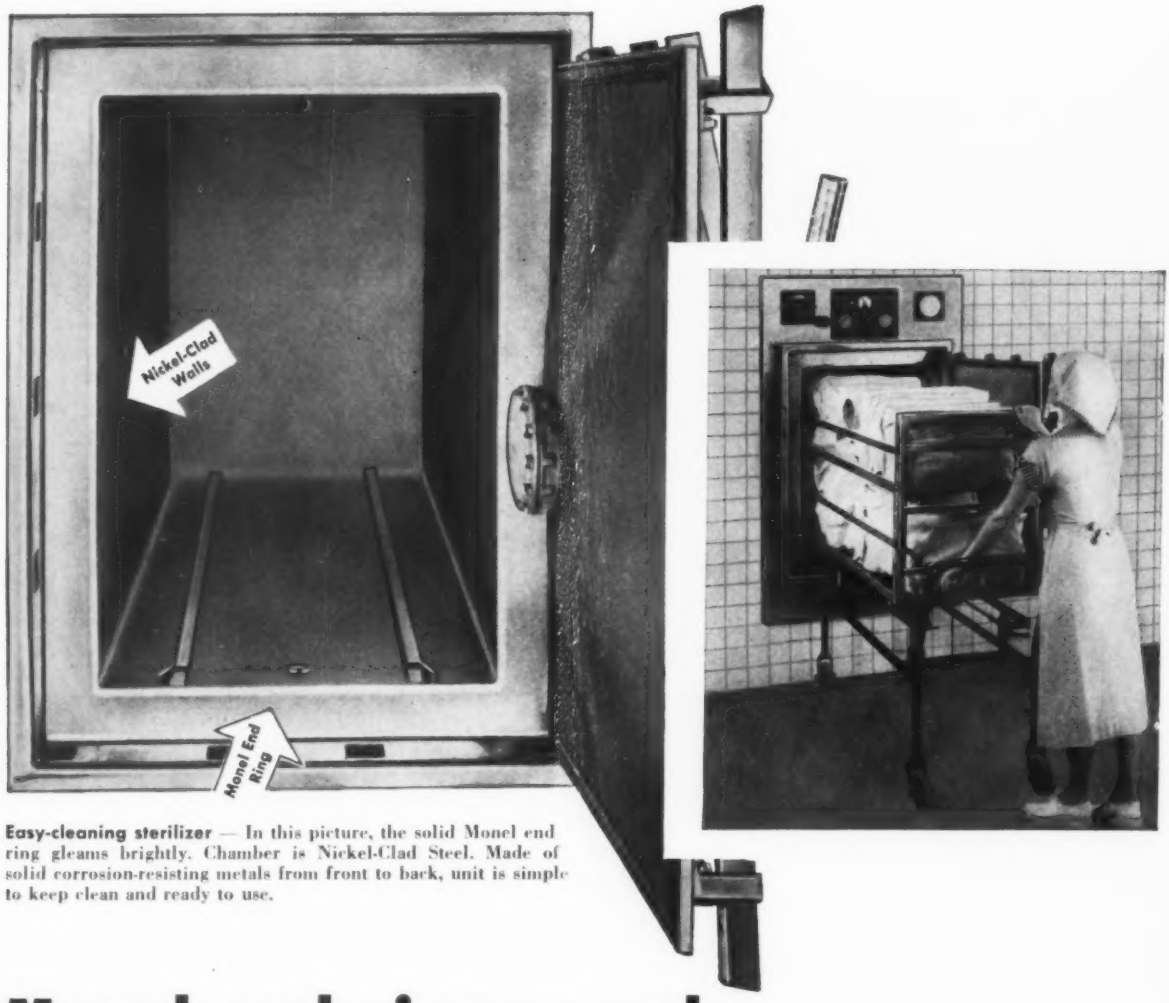

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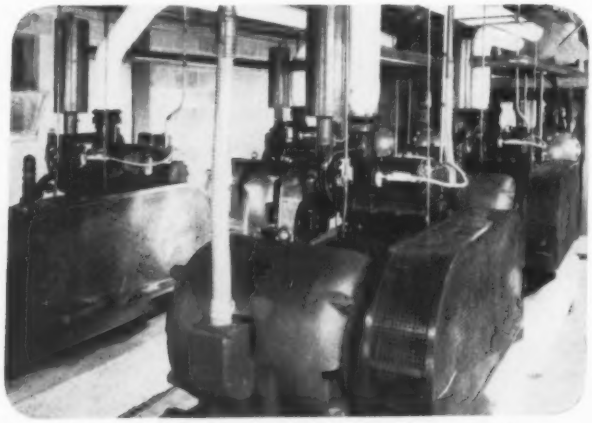

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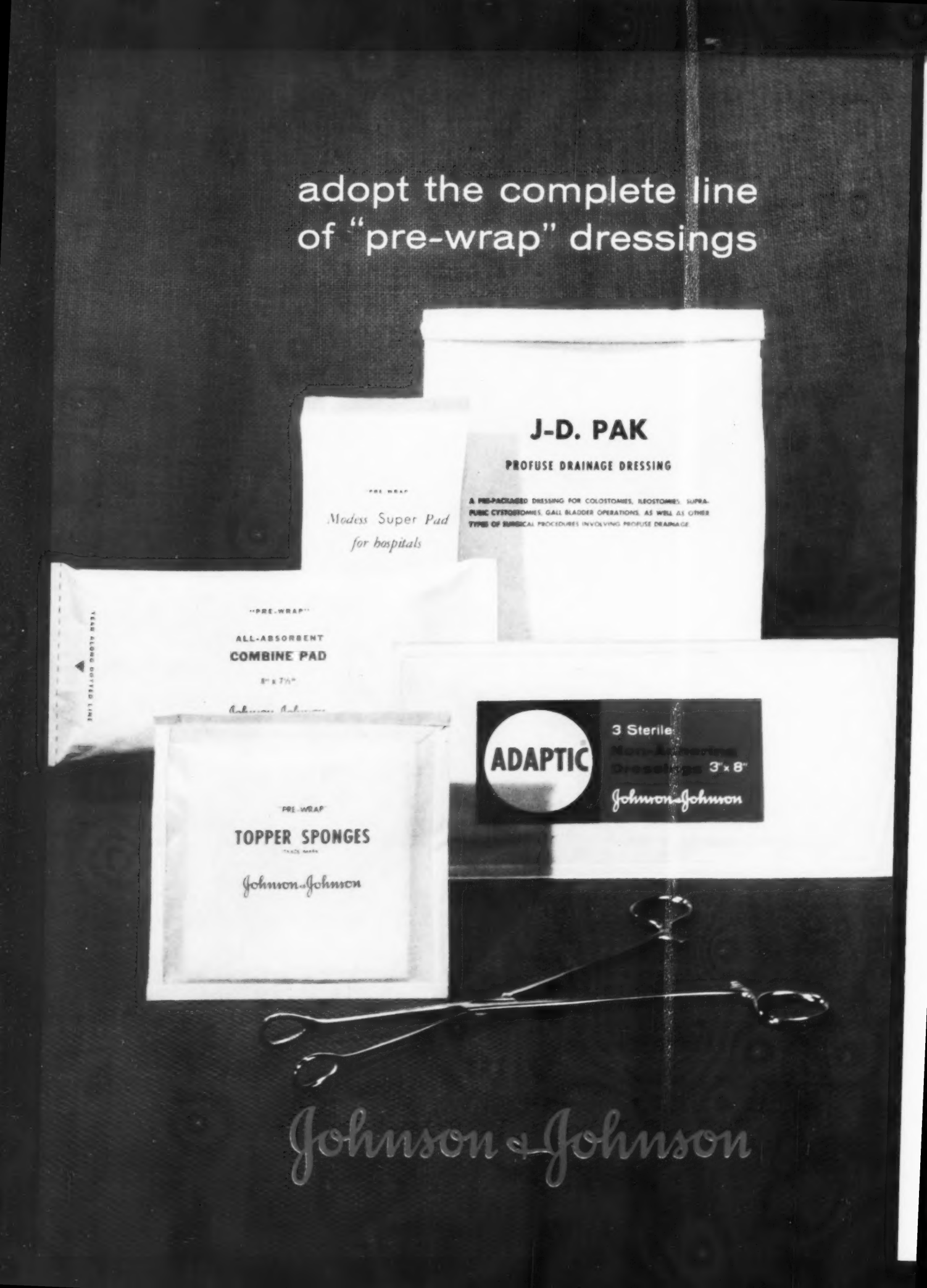
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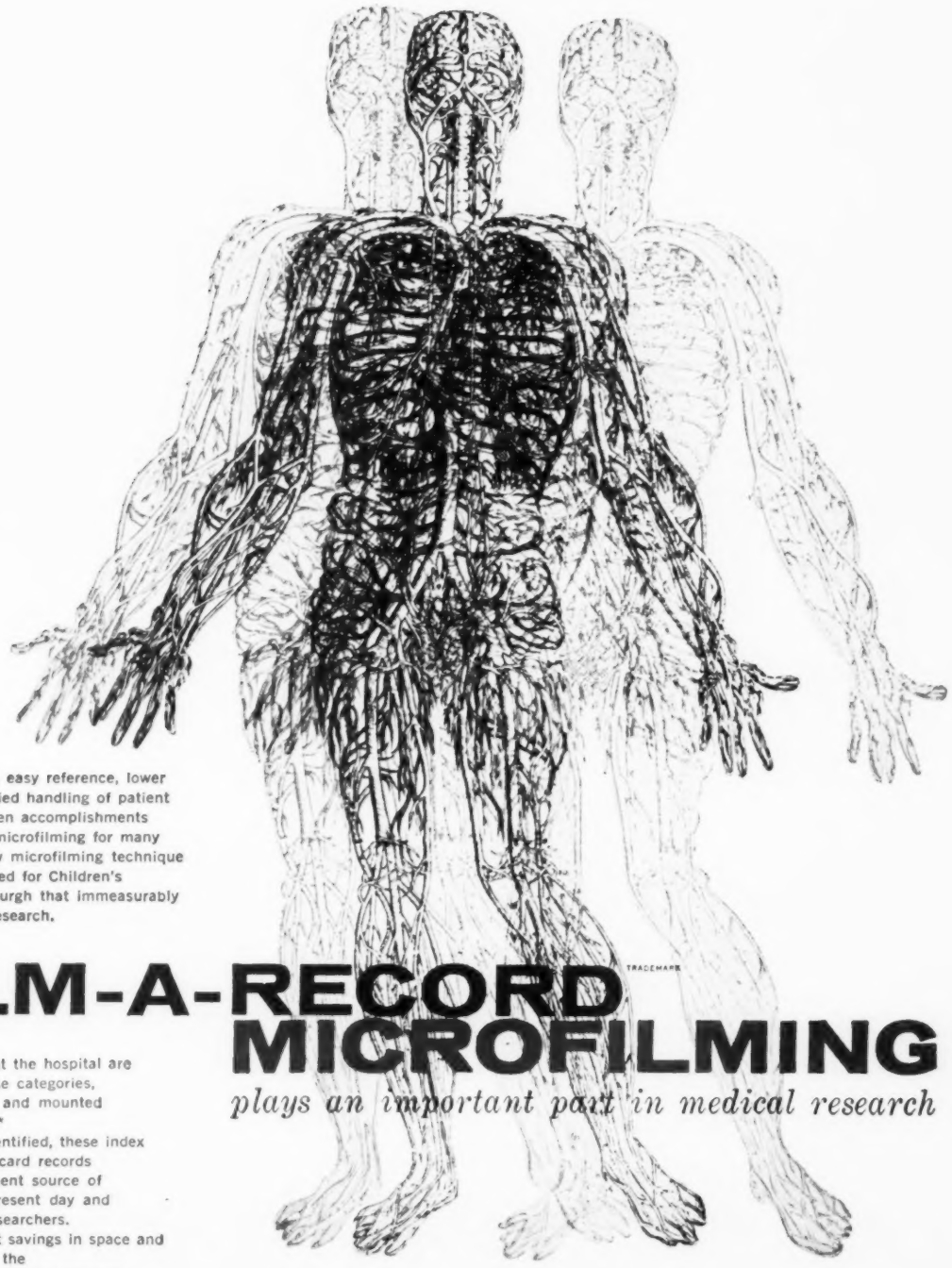

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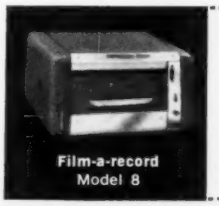

Film-a-record Model 8

I want the FREE folder describing Film-a-record at Children's Hospital of Pittsburgh.

NAME & TITLE_____
HOSPITAL_____
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CITY_____ ZONE___ STATE_____

*FilmSort is a registered trademark of Dexter Folder Co.

Johns-Manville Permacoustic Ceiling in the Penn Center Office of The Philadelphia National Bank, Philadelphia, Pa. Architect: James S. Hatfield and Lloyd Malkus Assoc.

Quiet the noise . . . add architectural beauty with a Johns-Manville Permacoustic® Ceiling

There's more value for the money in Johns-Manville Permacoustic units. You eliminate disturbing noise and beautify the ceiling at the same time.

Johns-Manville acoustical ceilings soak up noises like a sponge soaks up water. They deaden noise at its source, absorb it before it spreads. Over-all efficiency increases because of a general reduction in errors that result from noise distraction and nervous strain.

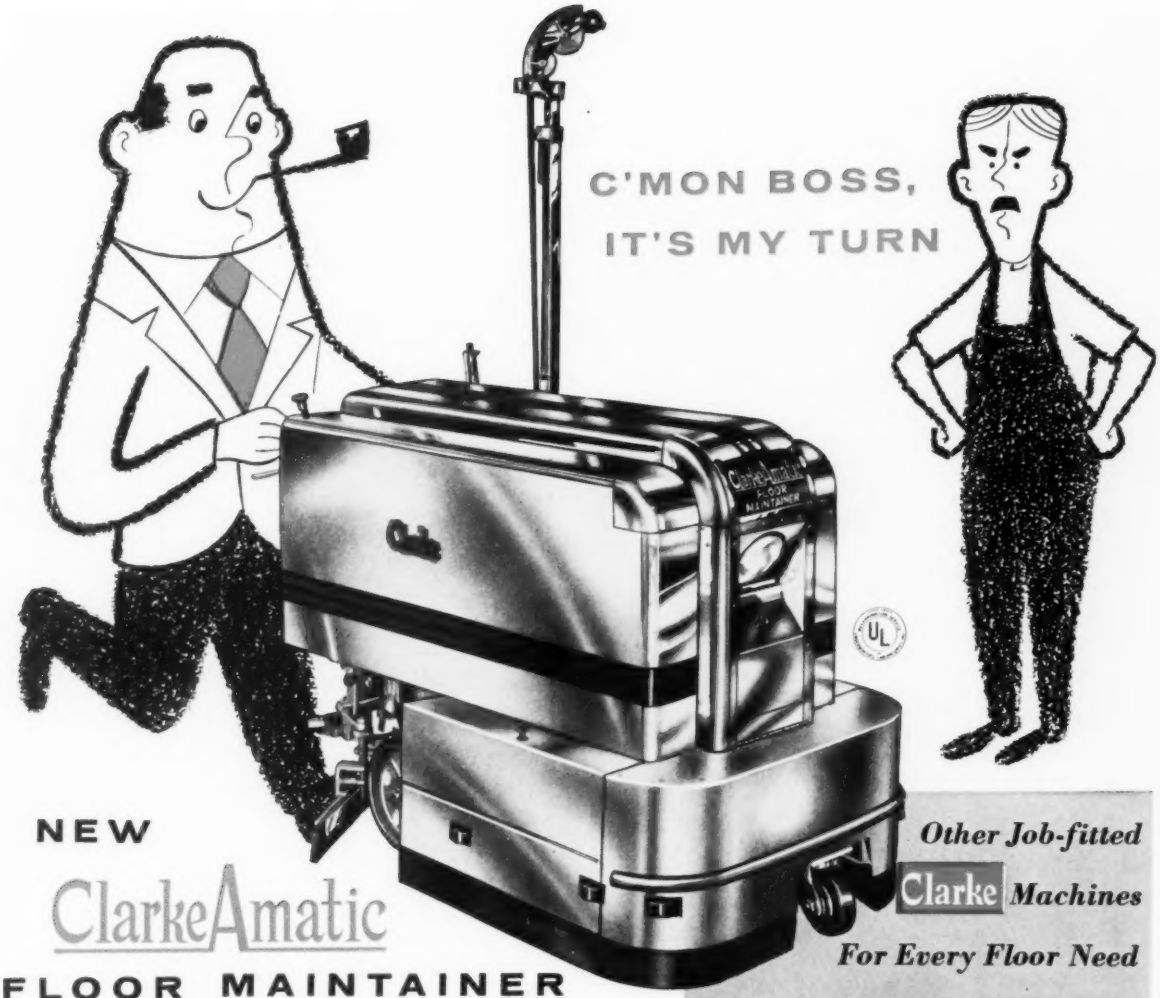
The textured finish of a Permacoustic ceiling is a decorative accent in architectural design. In conference rooms, executive offices, restaurants, banks, schools, etc., it complements the various components of interior decoration. Permacoustic is made of mineral wool, noncombustible fibres. You reduce fire hazard too.

Take advantage of the services of J-M's staff of acoustical engineers, located in the principal cities. They will gladly make analyses and give specific recommendations on your acoustical problems.

Before you decide about acoustical ceilings, get the facts about Johns-Manville. For a free copy of booklet "Sound Control," write Johns-Manville, Box 158, New York 16, N.Y. In Canada, write 565 Lakeshore Road East, Port Credit, Ontario.

See "MEET THE PRESS" on NBC-TV Sponsored alternate Sundays by Johns-Manville

JOHNS-MANVILLE JM PRODUCTS **Johns-Manville**



NEW

ClarkeAmatic

FLOOR MAINTAINER

Everyone is all fired-up over the Clarke-A-matic, the revolutionary new combination speed scrubber and vacuum. And no wonder. This two-speed, self-propelled floor maintainer automatically meters solution to its twin brushes, scrubs, rinses, picks up dirt and solution, and dries — all in one easy operation. It gives clean, safe, sanitary floors ten to twenty times faster than ordinary mopping.

The Clarke-A-matic is packed with revolutionary features. The entire operating mechanism is housed within the machine. Concealed cable reel keeps operating vision clear. The 18 gallon recovery capacity of vacuum tank and 20 gallon capacity of clean water tank mean fewer stops for emptying, increased coverage per hour, lower cleaning costs. Two Clarke-A-matic sizes, 26" and 30" brush spread. Electrically operated, also supplied propane or gasoline powered. The 26" model scrubs up to 24,420 sq. ft. per hour; 30" model, up to 28,200 sq. ft. per hour. For large floor area maintenance, the Clarke-A-matic is unmatched.

Clarke SANDING MACHINE CO.

Authorized Sales Representatives and Service Branches in Principal Cities
Distributed in Canada: G. H. Wood & Co., Ltd., P. O. Box 34, Toronto 14, Ontario

Other Job-fitted Clarke *Machines For Every Floor Need*

CLARKE VACUUM CLEANER—Powerful suction picks up liquids, suds, dust, dirt. Six different models.

CLARKE FLOOR MAINTAINER available in 7 different sizes. There are attachments for all eight jobs—scrub, polish, steel wool, buff, grind, disc sand, shampoo, wax.

SEND COUPON BELOW FOR COMPLETE INFORMATION

☐ Please send me complete details of the new Clarke-A-matic

☐ Clarke Floor Maintainer & Wet-Dry Vacuum Cleaner

Name_____

Address_____

City_____ State_____

CLARKE SANDING MACHINE CO.
526 Clay Avenue • Muskegon, Michigan

Kraft Red Label Shortening

. . . created for deep frying

This recipe for Fried Pies was developed in the Kraft Kitchens for use by the Food Service Industry.

FRIED PIES

Ingredients for 24 servings

4½ cups flour, sifted
⅔ cup sugar
1½ tablespoons baking powder
2 teaspoons salt
⅔ cup Kraft Brown Label Shortening
1 cup milk
2 eggs, slightly beaten

* * *

Kraft Red Label Shortening
Confectioners' sugar

Sift dry ingredients together; cut in shortening. Add milk and eggs to form soft dough. Roll dough thin; cut with 4-inch round cutter. Place a rounded tablespoon of filling on half of each round. Wet the edge; fold other half of dough over filling and press edges together with fork. Deep-fry in Kraft Red Label Shortening at 375° for 1¼ minutes. Drain; sprinkle with confectioners' sugar; serve hot.

Apple Filling—1 pint for 24 servings: Combine 1½ pints canned apples, drained, ½ cup sugar, ¼ teaspoon cinnamon. Simmer ½ hour, stirring occasionally; cool.

Kraft Red Label Shortening deep-fries better at lower cost because it was formulated especially for use in your fry kettles.

This hydrogenated shortening is made from choice vegetable oils. It offers long frying life and high stability. There is less fat loss because absorption is low. Foods fried in Kraft Red Label have an appetizing color and are deliciously crisp.

Give Kraft Red Label a trial in your fry kettles—see the difference the *right* shortening can make!

There's a right Kraft Shortening for every need. **BLUE LABEL**—your hydrogenated all-purpose shortening. **BROWN LABEL**—your high emulsifying shortening for fine baking. **GREEN LABEL**—your economical standard shortening. **RED LABEL**—your specially formulated shortening for deep frying. All available in 50-lb. and 110-lb. drums, and in 50-lb. cartons

KRAFT Foods Company INSTITUTIONAL DIVISION

THE NATION'S TASTE IS YOUR BEST BUYING GUIDE

How *high velocity* solves problem of *flexibility* in the Medical Towers

When the new Medical Towers Building in Houston, Texas was planned, the key air conditioning problem was flexibility. Professional office areas had to be subdivided *after* the building was completed. Here's how an Anemostat dual duct high velocity air distribution system solved the problem.

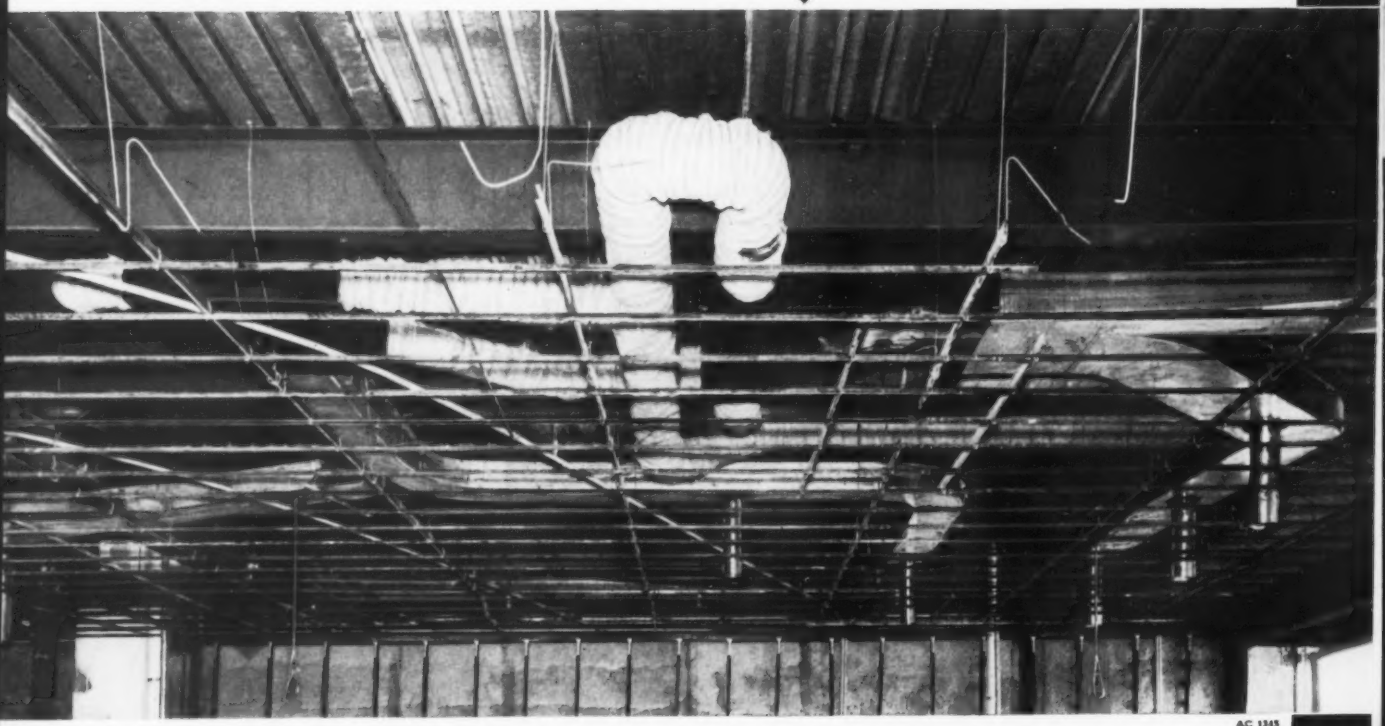
As shown in the diagrammatic sketch, a system of perimeter take-offs from the hot and cold ducts enables each doctor to provide the exact temperature he wants. Temperatures in the various rooms of each suite of offices can be varied. Air distribution is draftless, comfortable, perfectly suited to tenants' needs.

The Anemostat All-Air High Velocity distribution system offers further important advantages. It can be used with smaller than conventional ducts. It can be installed in less time and at less cost. It requires no coils, thus eliminates leakage, clogging and odors.

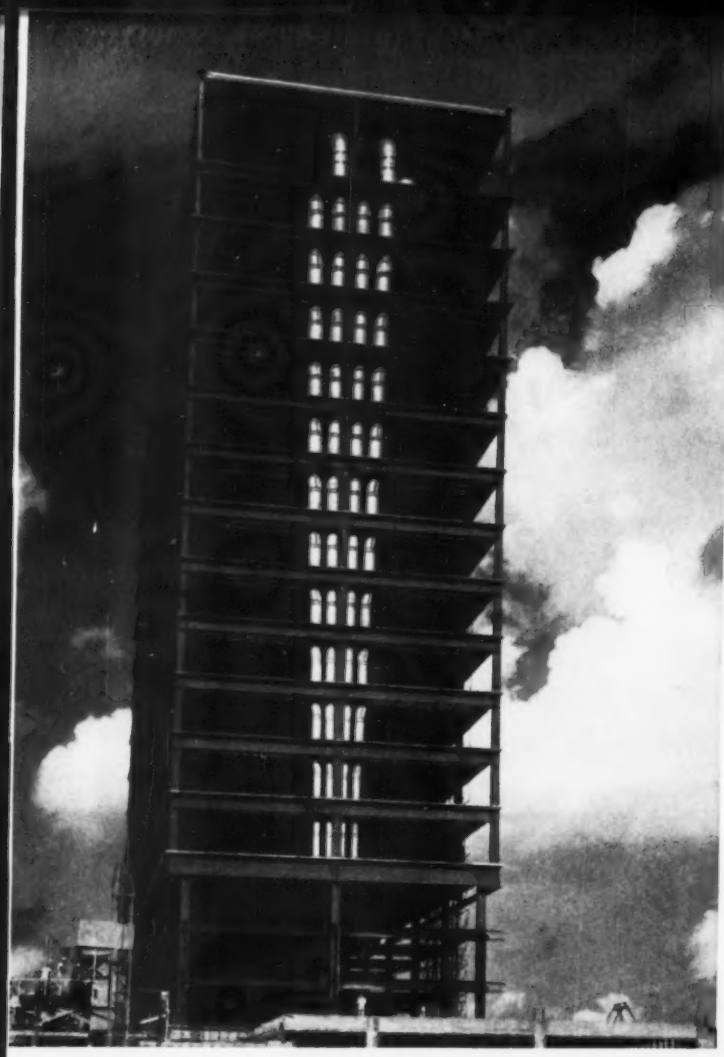
ARCHITECTS—Attention Please:
Anemostat round, square and straightline diffusers with high velocity units are adaptable to a wide variety of architectural designs.

Architects: Golemon and Rolfe, AIA, Houston
Consulting Architects: Skidmore, Owings and Merrill, New York
Consulting Engineers: Bernard Johnson and Associates
General Contractor: Tellepsen Construction Co.
Air Conditioning Contractors: Straus-Frank Company

Anemostat HPE units and duct connections installed in office before construction of ceiling and walls



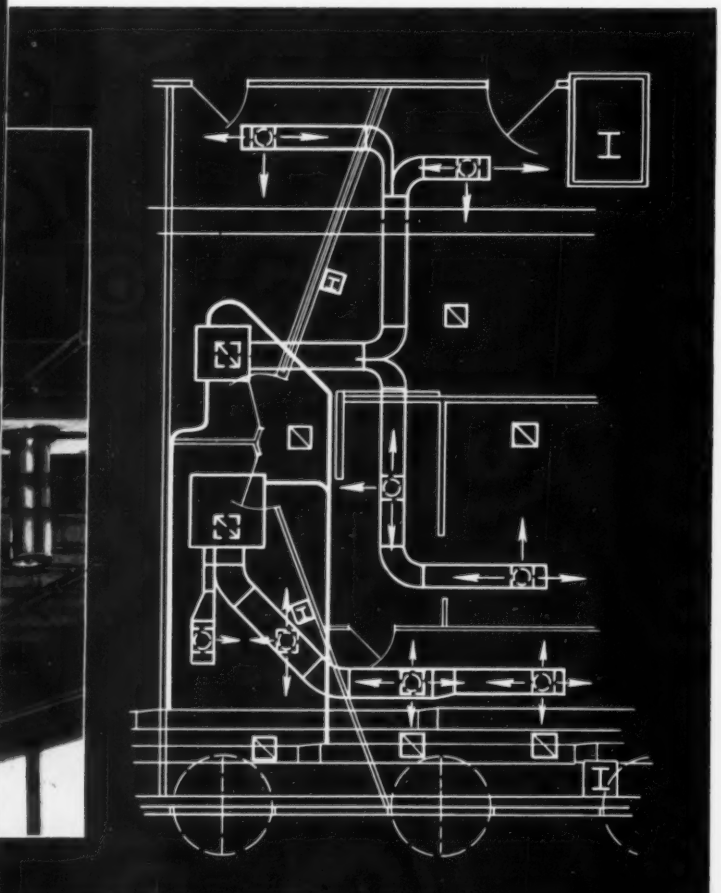
AC 1345



◀ Note how locating of hot and cold ducts saves space in new Medical Towers Building, Houston, Texas

View of lobby showing Anemostat Air Diffusers

View of professional reception room



◀ Layout of typical suite

Write on your business letterhead for your copy of

New Anemostat Selection Manual 60

to Anemostat Corporation of America, 10 East 39 Street, New York 16, N. Y.

ANEMOSTAT: The pioneer of All-Air High Velocity Systems

MAXIMUM PATIENT COMFORT . . .
MAXIMUM ATTENDANT CONVENIENCE *with the*

Specially Engineered **COLSON**

Post Anesthesia Stretcher

Now one nurse can easily care for up to 12 patients in the post-operative room.

Every feature of the widely used and extra long COLSON PA Stretcher is designed for patient comfort, safety and to save nurses' time. The two guard rails may be easily raised or lowered. The litter is hinged at one end and its position is controlled by a single crank-operated elevating mechanism. Two special brake casters facilitate traveling down halls or render the stretcher immobile. Durably constructed for years of dependable service, the COLSON PA Stretcher is beautifully finished in stainless steel or gray enamel.

FOR FOOD
SHELF TRUCK
No. 10-6332

FOR LINENS
SPACE-SAVER LINEN HAMPER
No. 6612-6

FOR GAS TANKS
TANK TRUCK
No. 6585

FOR PATIENTS SERVICE
SCIENTIFIC INSTRUMENT TABLE
OVER THE BED TABLE
No. 6375

SURGICAL TABLE
No. 6370

STRETCHER
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No. 4255

INHALATOR
No 4953

RECLINING BACK CHAIR
No. 4424 X2

No. 1-5267-73 No. 4-807-65 No. 3-1013-74
COLSON CASTERS SAVE YOUR FLOORS

smoother—quieter—faster rolling
first choice for lasting efficiency

Whether administering treatments, serving in surgery, wheeling patients or rolling materials and supplies, the complete COLSON line offers the finest in quality materials and workmanship.

The Colson Corporation · General Offices, Elyria, Ohio

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Write Today for FREE, Complete Catalogs!

Colson®

Wash 'n Dri

The miracle moist Towelette!

WASHES HANDS AND FACE
WITHOUT WATER, SOAP, TOWEL

RRW

SAVE THOUSANDS OF DOLLARS IN EXPENSIVE BEDSIDE CARE

Sealed, saturated Wash 'n Dri tissues save nursing time—cleanse, cool, soothe patients.

1. Hermetically sealed, saturated, antiseptic tissues for bedside use and patients' meal trays.

2. Save attendants' and nurses' time for washing up, cooling, soothing patients.

3. Easy to open, no towel needed, air-dries in seconds, leaves skin smooth, soft clean.

4. Useful for bathing children during fever, cooling and comforting patients after surgery, childbirth, and dental extractions.

Used in hundreds of hospitals from coast to coast

The Berkshire Eagle—April 9
PITTSFIELD, MASS.

Wash Tissues Given Trial At St. Luke's

Wash basins, water pitchers, soap, washcloths and hand towels have been replaced at St. Luke's Hospital by matchbook-sized alcohol-dampened tissues.

Sister Superior Marie Reparatrice, hospital administrator, said the tissues, known as Wash 'n Dri, are being used both as a time-saver for hospital employes and as a convenience for the patients.

Packed in aluminum foil, the towelettes are easily unfolded to 6 by 8 inch size. The alcohol solution cleans, cools, refreshes and dries by evaporation.

Patients get their daily bath in the usual way, but they much prefer Wash 'n Dri for the early morning washup, after meals, after reading newspapers and whenever they want to feel clean and cool, the administrator said.

"In addition to saving countless nursing hours, the patients are happier with the new service," Sister Superior said. St. Luke's is one of the first hospitals in the country to adopt the system.

Wash 'n Dri is made by R. R. Williams Inc. of Canaan, Conn. The towelettes are particularly handy in water shortages and other emergencies.

WRITE FOR SAMPLES AND MORE INFORMATION ABOUT

WASH 'N DRI

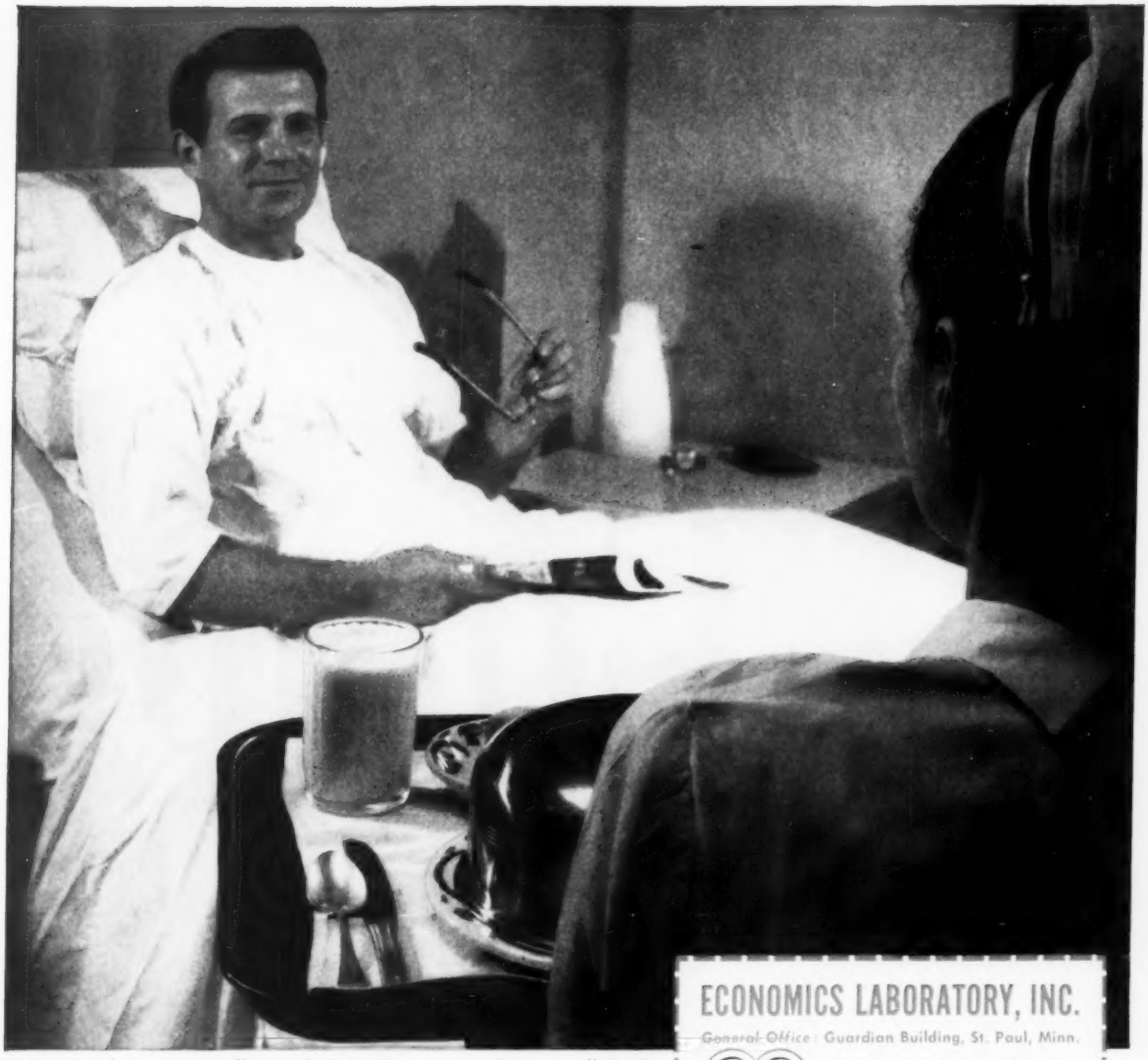
TO: WASH 'N DRI, CANAAN, CONNECTICUT
Please send me samples of WASH 'N DRI

Name_____

Address_____

R. R. WILLIAMS, INC., CANAAN, CONN.

How to cut per-patient cost **with every meal you serve**



Dishes dried "automatically" with E.L. DRYMASTER eliminate *all* hand toweling, bring per-patient meal costs down overnight.

Dishwashing costs—compound, manhours, breakage and towel expense—may make the difference between break-even and loss on a per-patient-meal basis. That's why an E.L. DRYMASTER on your dishmachine is both wise management and sound hospital practice.

DRYMASTER ends all toweling of tableware by injecting "Rinse Dry" into the final rinse of your dishmachine. "Rinse Dry" makes rinse water slip off in sheets rather than stand in droplets. Results: bone-dry tableware right from the machine. No toweling. No water spotting. No wasted manpower. Less handling and breakage. And less chance of contamination from soiled towels.

Installed free, DRYMASTER fits any size, make or model dishmachine, uses no electricity, needs no adjusting. And one 8 oz. bottle of "Rinse Dry" usually lasts all day. For the whole story, just mail the coupon. Or call your nearby SOILAX Sales Representative (in the "yellow pages" under cleaning compounds).

ECONOMICS LABORATORY, INC.

General Office: Guardian Building, St. Paul, Minn.

Exec. Sales and Advtg. Offices: 250 Park Ave., New York 17, N. Y.

☐ Have representative call

☐ Send complete information on DRYMASTER

*Name*_____

*Title*_____

*Hospital*_____

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*City*_____

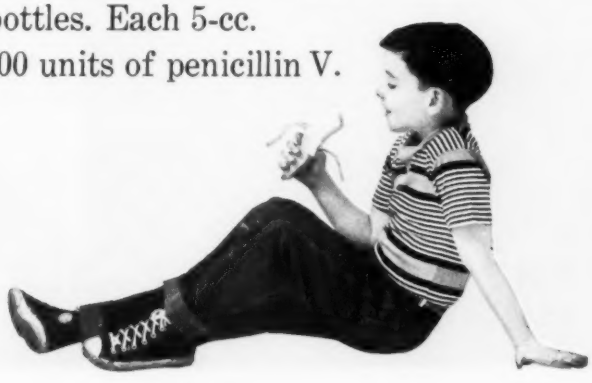
*State*_____

penicillin V

Cillin®-V

to-take forms

In SUSPENSION . . . Little patients get a delicious, banana flavor. Ready-mixed COMPOCILLIN-V Suspension comes in 80-cc. bottles. Each 5-cc. teaspoonful represents 300,000 units of penicillin V.



Abbott

Now!

A BETTER TECHNIQUE FOR PATIENT UTENSILS . . .

THE *American* UTENSIL WASHER-SANITIZER

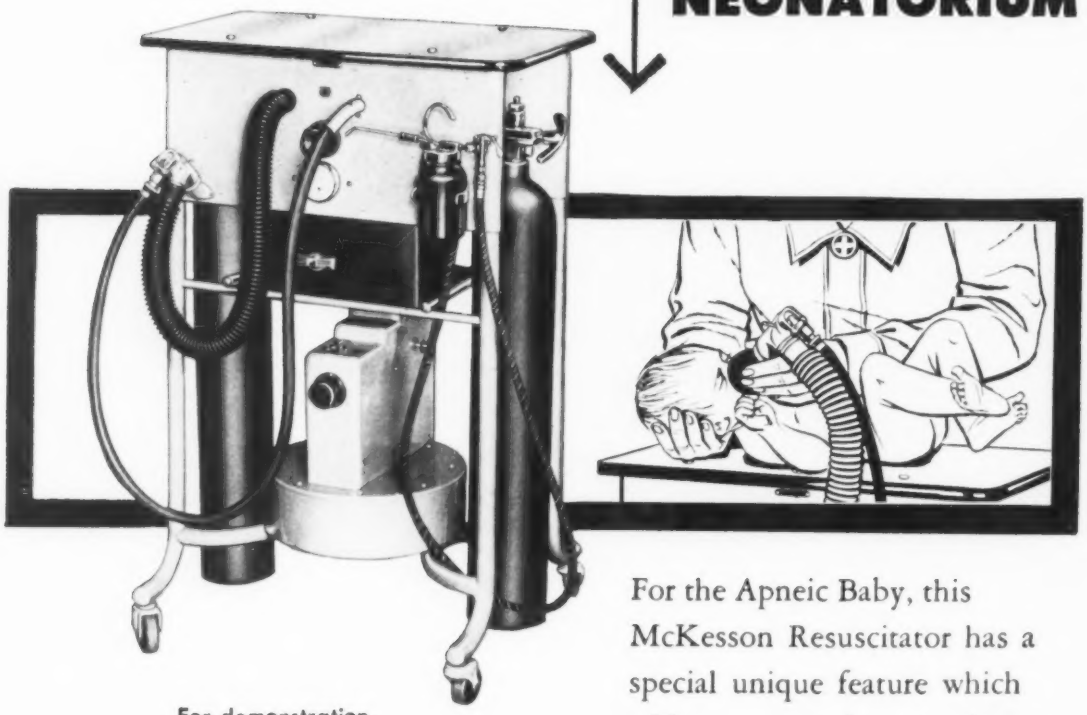
• The American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces Utility Room clutter and assures uniform cleaning and sanitizing at less cost.

For complete information on this new Utensil Technique, write for bulletin SC-321.

The American Utensil Washer-Sanitizer is available with stainless steel Utility Room clean-up counter or as the free-standing unit shown above.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

superb convenience FOR ASPHYXIA NEONATORIUM



For demonstration, ask your salesman. Or write for McKesson Resuscitator Brochure.

For the Apneic Baby, this McKesson Resuscitator has a special unique feature which adds up to superb convenience—

The baby suffering from Asphyxia Neonatorium is laid directly over the equipment—on the Table Top—where treatment is easiest and quick!

McKesson
RESUSCITATORS

McKESSON APPLIANCE CO. • TOLEDO 10, OHIO

No Dream...this *Theme* hospital room by Simmons

But definitely practical in its concern for both patient and hospital staff. Every piece is the result of alert research, careful design, and Simmons' years of experience with, and appreciation of, modern hospital requirements. Created by the noted industrial designer, Mr. Raymond Spilman, *Theme* hospital furniture is constructed of sturdy, long-life metal that reduces maintenance to a minimum. Modular units permit efficient use of available space and an almost limitless variety of attractive arrangements.

In the room illustrated, furniture color is soft Heather Green. Desk-dresser is made up of modular basic three-drawer small case unit under a 58½" long top. Bedside Cabinet 30" high means greater patient comfort with the Single-Action Vari-Hite Hospital Bed. Textolite table tops, Naugahyde upholstery and famous Beautyrest mattress built especially for hospitals mean that comfort and beauty go hand-in-hand with durability. You'll find *Theme* costs are surprisingly moderate, too. It's the common-sense solution to building, modernizing, decorating problems.

Your Simmons agent or nearby Simmons office is always ready with advice based on nationwide hospital experience.

SIMMONS COMPANY

DISPLAY ROOMS:
Chicago, New York, San Francisco, Atlanta, Dallas, Columbus, Los Angeles

Which ice is best for you?

for motels, hotels, restaurants, cafeterias, hospitals

water, tea, coffee	cubes	crushed	chips
mixed drinks	cubes	crushed	
seafood, relishes, salads		crushed	chips, flakes

for supermarkets, meat markets, produce and fish markets

food displays			chips, flakes

Take your pick . . . with Carrier Certified Capacity instead of "up to" so many pounds per day.

1. Carrier offers the most complete line of ice machines on the market, to make the right kind of ice for your exact needs. 15 models for cubes, crushed, flakes, chips.

2. Carrier gives you capacity *certified in writing!* Carrier ice machine production figures are determined by *local* air and water temperatures—not those found in some remote laboratory!

Your Carrier dealer can point out other interesting things, too, like savings of 80% or more on ice bills. He'll never ask you, "won't this ice do just as well?" And he'll never give you a production figure "up to." He lays it on the line . . . a Certified Capacity *full line.* Phone him today. He's listed in the Classified Directory.

Icemaker Chipmaster Flakemaster

Carrier air conditioning • refrigeration

the NEW APPLETON "NXFI" non-explosion-proof x-ray FILM ILLUMINATOR

(for non-hazardous areas)

- ✔ *high quality, lightweight construction*
- ✔ *portable or surface mounting*
- ✔ *economically priced*
- ✔ *full view of x-ray*

1. Flush Mounting

2. Surface Mounting In Operating Room

3. Portable Cart Mounting For Ward Use

4. Cart Mount For Reading Rooms

New from APPLETON . . . this truly outstanding X-ray film illuminator with practical, plus features for amazing versatility throughout your hospital. Can be used for wet (stainless steel drip tray available at additional cost) or dry film viewing under strong full panel illumination with no shadows. The "NXFI" may be surface mounted above the 5 ft. level in operating rooms, reading rooms, etc., in single, double, or unlimited banking in whatever grouping is particularly efficient for your use . . . at surprisingly low initial cost.* The "NXFI" is truly portable, and may be cart mounted for ward or reading room use. In all cases, each unit operates separately. When needed, relamping is quickly and easily accomplished by removing two screws and plexiglass viewing panel.

We think you'll agree this NEW APPLETON "NXFI" non-explosion-proof Film Illuminator with all its quality features is your very best illuminator value.

*accessory mounting kit available which makes multiple unit mounting possible.

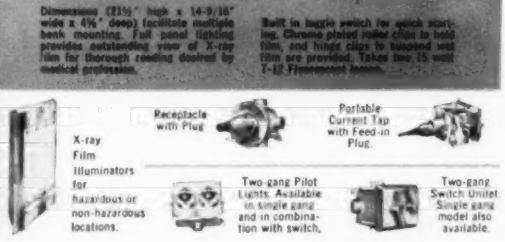
Dimensions (21½" high x 14-9/16" wide x 4¾" deep) facilitate multiple bank mounting. Full panel lighting provides outstanding view of X-ray film for thorough reading desired by medical profession.

Built in toggle switch for quick starting. Chrome plated roller clips to hold film, and hinge clips to suspend wet film are provided. Takes two 15 watt T-12 Fluorescent lamps.

Sold Through Franchised Wholesalers Only

APPLETON ELECTRIC COMPANY

1743 Wellington Avenue • Chicago 13, Illinois



X-ray Film Illuminators for hazardous or non-hazardous locations.

Receptacle with Plug

Portable Current Tap with Feed-in Plug.

Two-gang Pilot Lights. Available in single gang and in combination with switch.

Two-gang Switch Unilet. Single gang model also available.

Automation doubles laundry capacity at The Springfield Hospital

No increase in floor space — 280 man hours saved per week

Automation—Key to high production, labor-saving laundry department at The Springfield Hospital, Springfield, Mass. American-equipped Automatic Washroom and Mechanized Flatwork Finishing Department have doubled the laundry's capacity, cut supply costs 20% and *reduced the labor force by 7 operators!*

See how automation will increase the efficiency and productivity of *your* laundry department. Your nearby American Man from the Factory has all the information. Call him today, or write for Catalog AI 321-002.

Automatic Washroom

Sixteen tons of work are processed every week in The Springfield Hospital's high-production Automatic Washroom. Now, Cascade Unloading Washers with Full-Automatic Controls perform all phases of washing cycle *without operator attention!* Pushbutton unloading automatically empties washed work directly into Notrux Extractor containers. Electric hoist and overhead trolley quickly convey containers to and from high-speed Notrux Extractors. Back-breaking manual chores have been completely eliminated in this up-to-the-minute laundry operation.

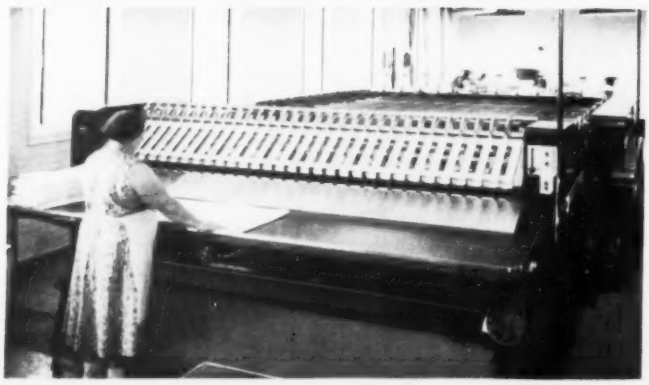
The American Laundry Machinery Company, Cincinnati 12, Ohio

Single-Ironer Mechanized Flatwork Department

Single-ironer flatwork finishing department at The Springfield Hospital is completely mechanized for top-speed production, fast return of linens to service. Work is conditioned, conveyed, ironed and folded *automatically!* American automatic equipment saves labor and handling, reduces operator fatigue and greatly improves employee morale.

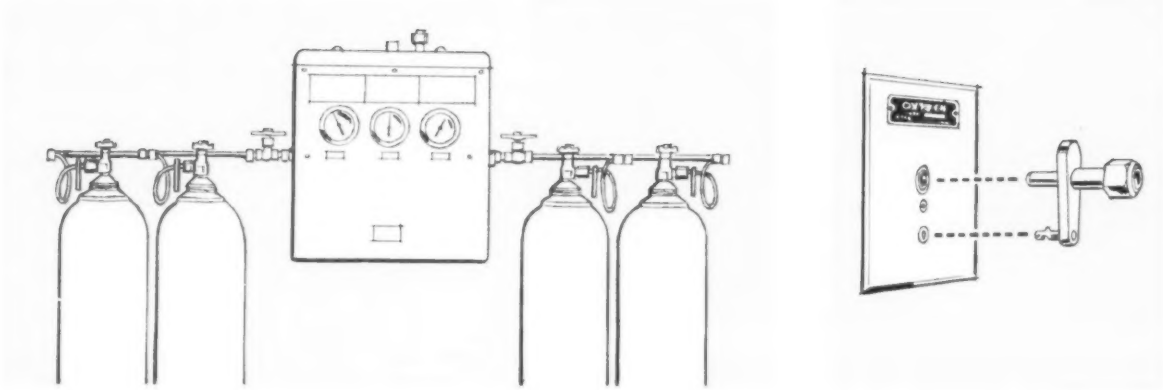
Extracted work is conveyed automatically into and from Rotaire Conditioning Tumbler! Manual shakeout is eliminated, both large and small pieces flow to ironer continuously, perfectly heat-and-moisture-conditioned for fine quality finishing at high speeds.

Sheets and other large pieces from Rotaire Tumbler are delivered to ironer feeders at rates of more than 700 per hour by high-speed Sager Spreader. All large linens are opened and smoothed for fast, easy feeding, travel in full view of operator for thorough inspection. Conditioned small pieces are conveyed directly to ironer feeders.

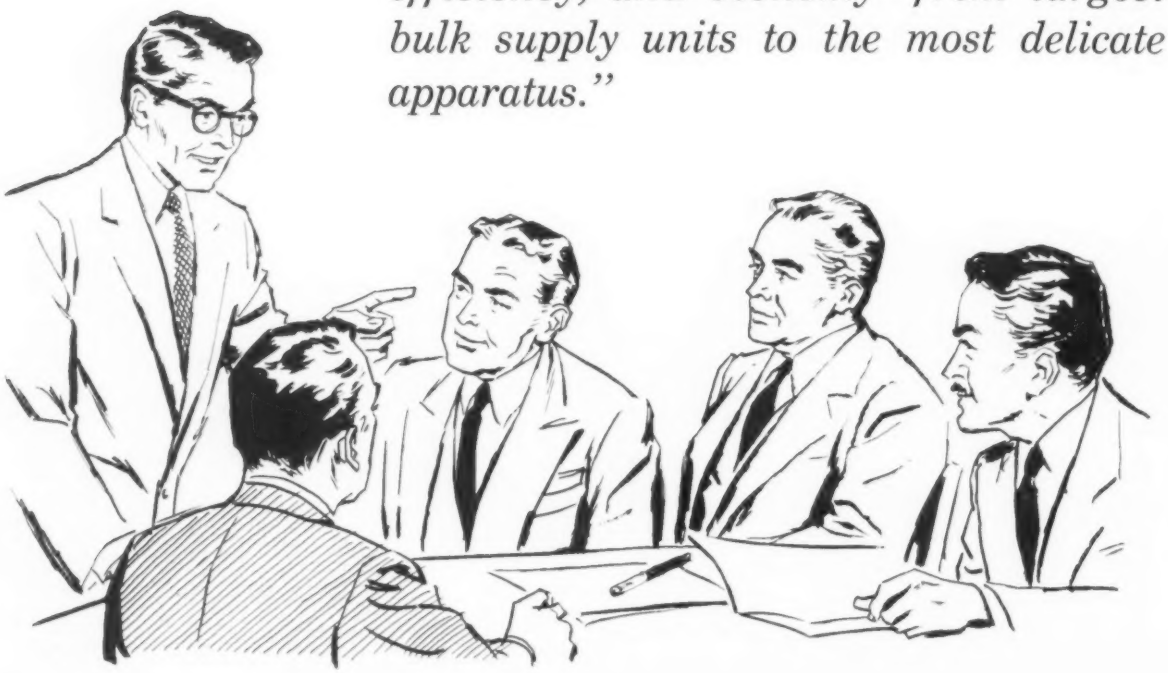


Both large and small pieces are automatically folded directly from ironer by Trumatic Folder. Automatic measuring device guarantees a neat, even edge on every folded piece. Transfer back and forth from single lane (for large pieces) to two lane (for small pieces) is automatic.

from installation



"NCG provides the means for administering inhalation therapy with security, efficiency, and economy—from largest bulk supply units to the most delicate apparatus."



to inhalation—

NCG service is complete. It begins with the planning of your piping system. We outline the savings you can realize by using piped oxygen. We recommend types and sizes of equipment. We supply a piping layout superimposed on your own floor plans. Then we cooperate closely with your contractor until the system is installed.

NCG service is continuous. It covers everything from the delivery of oxygen to the provision of the most effective apparatus for administering that oxygen to the patient. We feel it is our responsibility to work endlessly toward the perfection of new methods of inhalation therapy, and our representatives and research teams are always available to help solve your problems.

NCG service is dependable. In an NCG equipped hospital, you can be sure that the tiniest link in the chain from the delivery of oxygen to the hospital to the inhalation of oxygen by the patient has been developed with the greatest care. This applies equally to the small safety adapter that plugs into the outlet as well as the largest, most intricate control unit.

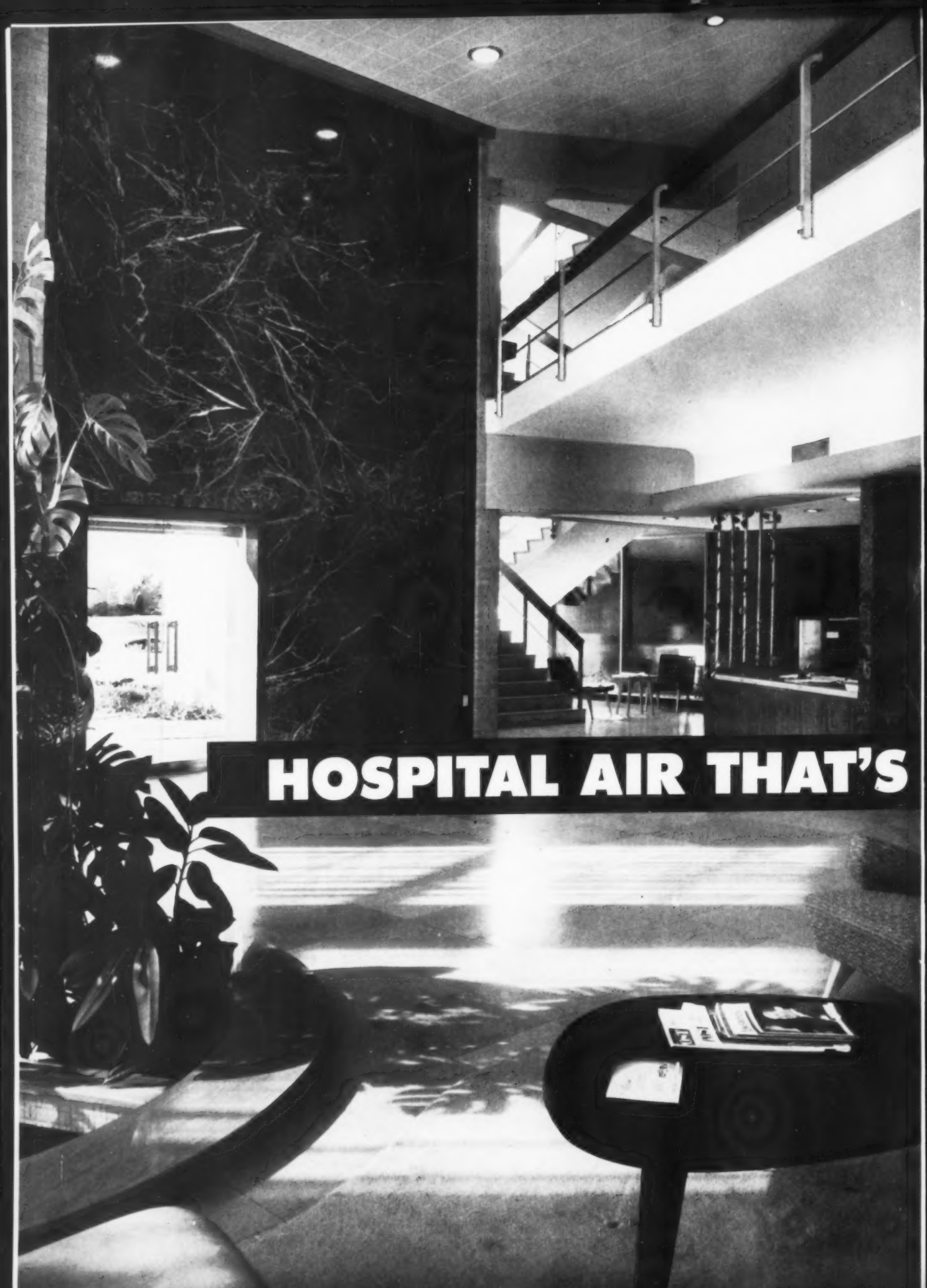
We are happy to have played an important role in making piped oxygen a "taken-for-granted" commodity in hospitals. More than 1200 NCG piped hospitals attest to the quality of NCG piped oxygen systems and terminal apparatus. We can be of service to you. Write for information.

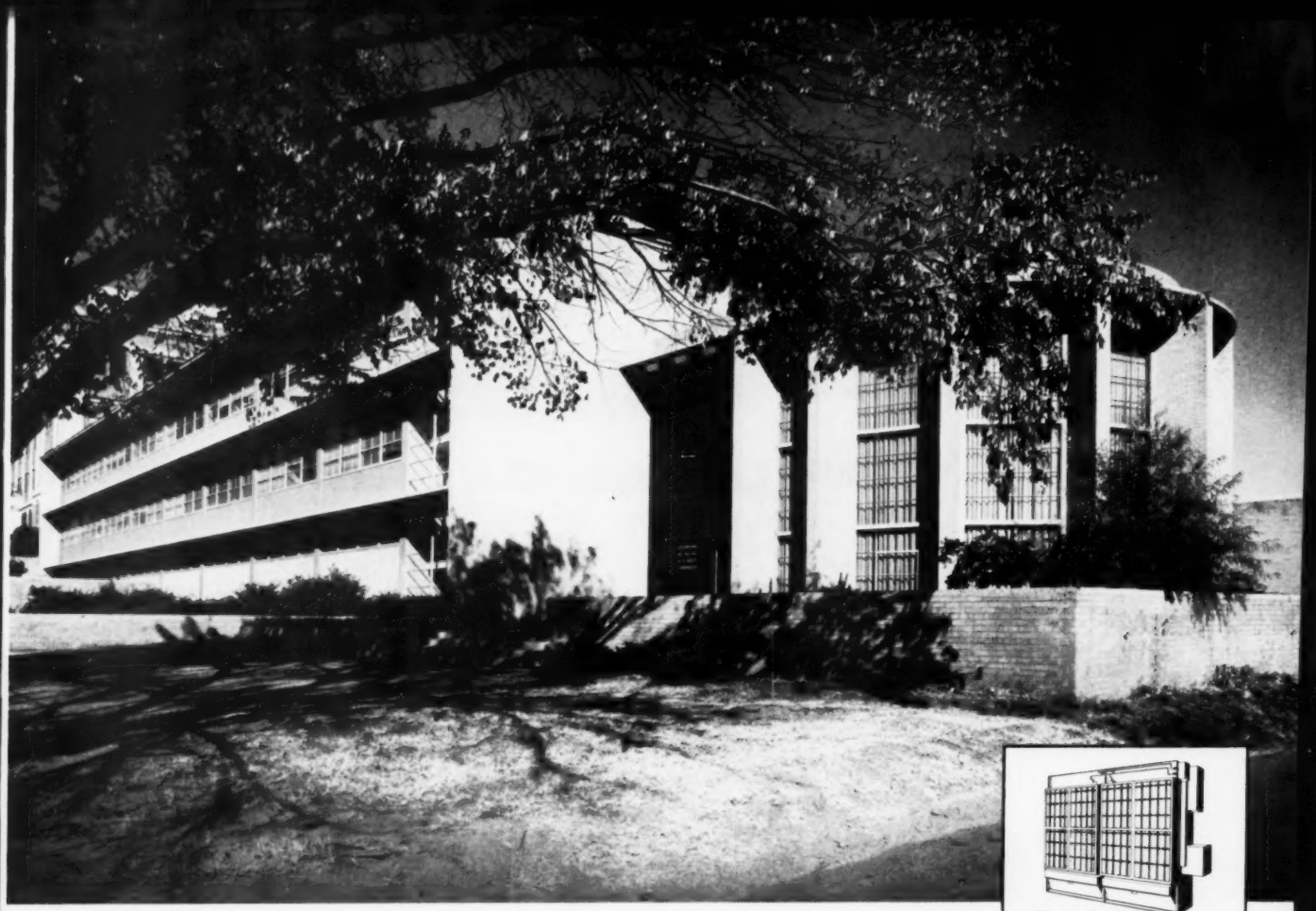
NCG®

NATIONAL CYLINDER GAS COMPANY

840 North Michigan Avenue • Chicago 11, Illinois

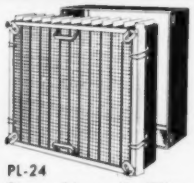
OFFICES IN 56 CITIES


HOSPITAL AIR THAT'S



Oklahoma Medical Research Foundation, Oklahoma City. Architects and engineers: Coston-Frankfurt-Short, Oklahoma City; Mechanical Contractor: J. J. Bollinger Construction Company, Oklahoma City.

Electro-Matic
Electrostatic Precipitator



PL-24
Renewable-media Filter

HOSPITAL CLEAN!

For a building that houses medical research laboratories and a small hospital, ordinary "clean" air isn't clean enough. The air must be *super-clean . . . hospital clean!* And the air in Oklahoma City's Oklahoma Medical Research Foundation is just that, thanks to clean-air engineering by AAF.

Two types of AAF air filters—Electro-Matic and PL-24—are filtering ventilation air throughout the building. The Electro-Matic is an electrostatic precipitator that removes even smoke from the air, and automatically cleans itself at the same time! The PL-24 is a unit filter featuring low-cost renewable filtering media. It's the world's most efficient mechanical filter for ventilating and air-conditioning service.

AAF makes a *complete line* of filters. This assures you of the *efficiency you need* plus the *maintenance characteristics you want*. For further information, call your nearby AAF representative or write direct.

AAF herman nelson

American Air Filter
COMPANY, INC.

415 Central Avenue, Louisville 8, Kentucky
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THE OHIO CHEMICAL LABEL on the cylinder of cyclopropane is your assurance of purity and uniformity *beyond the usual standards.* Rigid specifications for raw materials, individual tests for purity during all stages of production and final analytical tests on the contents of each cylinder insure cyclopropane at least 99.5% pure — *greatly exceeding USP requirements.*

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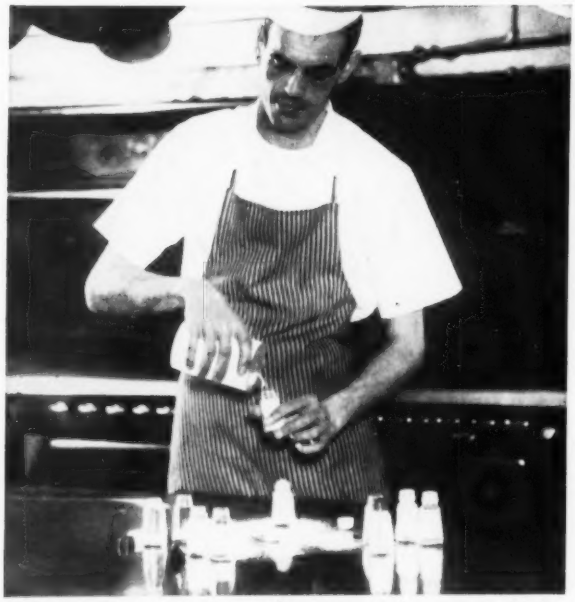
How Diamond Crystal seasoning packets end danger of cross-infection from dispensers



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Diamond Crystal packets are individual seasoning containers. They are disposable and sanitary. Need no servicing. And your patients appreciate their modern convenience.

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Old-fashioned seasoning dispensers can be an expensive problem to hospitals. They get dirty quickly. Shakers and bowls need constant cleaning. Re-filling. Sterilizing.

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Packets solve problem

Diamond Crystal seasoning packets are disposable. Hygienic. Eliminate dangers of cross-infection from dispensers.

Each packet contains a generous serving of either pure Diamond Crystal salt; spicy ground black pepper; or fine granulated sugar. When the patient finishes his meal, the packets are thrown away.

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Only Diamond Crystal packets let you *shake on* seasoning. Their sturdy fluted paper construction allows the same *method* of application as old-type dispensers—without the costly need of regular washing, filling and sterilizing. Your saving on dispenser servicing alone more than makes up for the slight additional cost of packets.

Exclusive "Shaker action" of Diamond Crystal packets allows controlled application of seasoning.

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See for yourself how Diamond Crystal packets can save you time and money. Just mail the coupon below. You will receive a free sample box of 100 Diamond Crystal salt, pepper and sugar packets for your own use by return mail.

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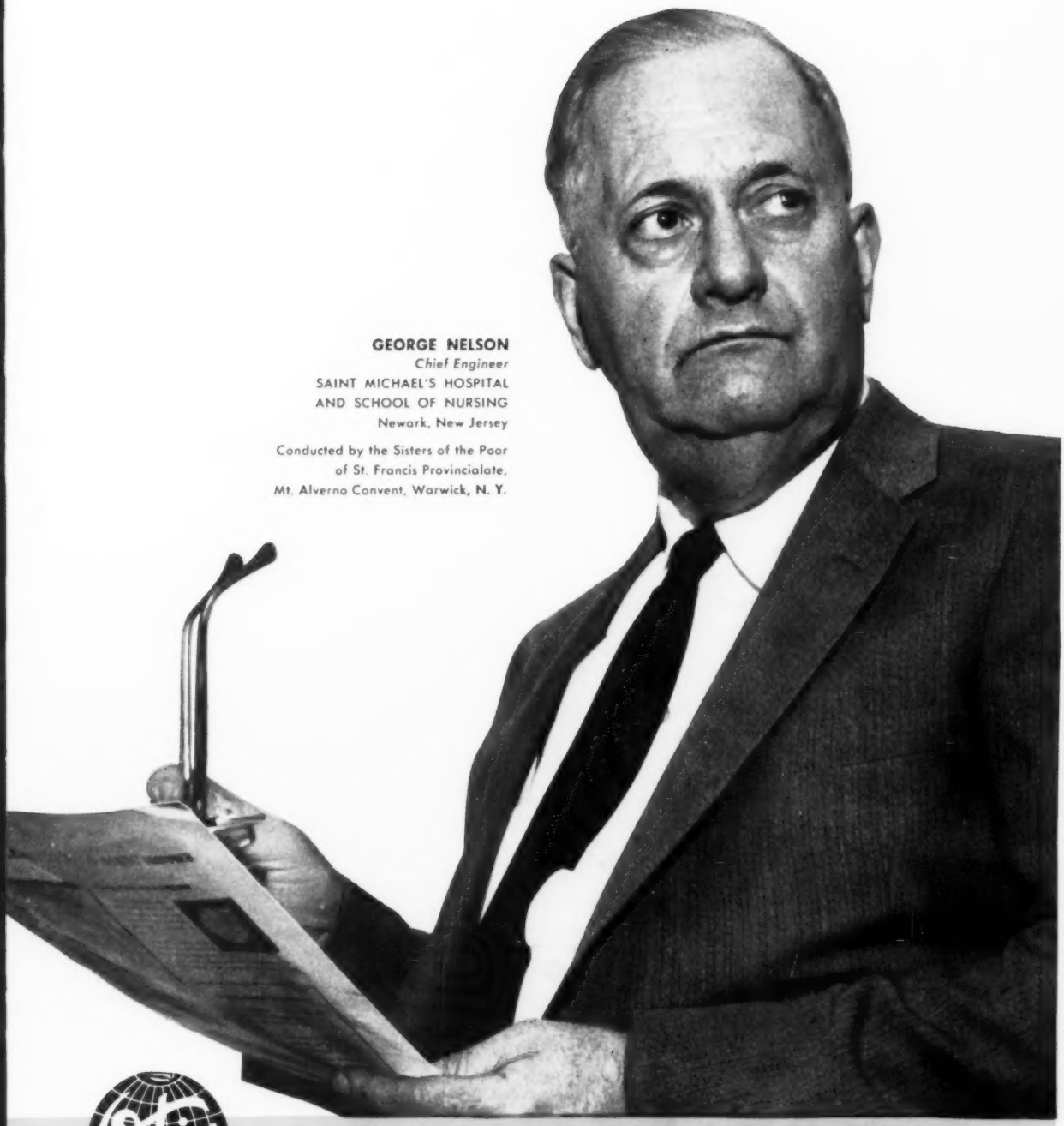

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banded color-on-color

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Also available in solid and textured colors, and in decorated patterns.

SMALL HOSPITAL QUESTIONS

Need for Hot Air Sterilizer

Question: We have recently moved into our new 32 bed hospital. We have one 18 by 24 inch flash autoclave sterilizer and one 20 by 36 inch autoclave sterilizer. We also have a hot air sterilizer for sharp instruments. With no means of sterilizing instruments and water other than by autoclaving, our nursing department feels we have unwisely invested in the hot air sterilizer, and therefore urges that we return this piece of equipment and purchase another autoclave.

It seems that it takes eight hours to complete a sterilizing cycle in this hot air sterilizer. They further state that there is a question as to whether hot air sterilization will or will not kill spores.

Before making any changes, we would like to learn: (1) Are we permitting a weak link to exist in our sterilizing technic by not using hot air sterilization on sharp instruments, provided they are sterilized in the standard solution? (2) If hot air sterilization is important to sterilizing technics, why does not the accreditation commission insist on hospitals using this technic before accrediting them? At least three or four accredited hospitals in this area do not use hot air sterilization.—J.E.M., Calif.

ANSWER: 1. Sharp instruments can be thoroughly and quickly sterilized in a regular steam autoclave and many hospitals use this method. However, this procedure does have a tendency to dull sharp edges.

2. Instruments can be successfully sterilized in several solutions sold by reputable, well established companies. However, authorities generally believe that heat sterilization is safer.

3. Hot air sterilization of sharp instruments by exposure to hot dry air at 320° F. for one hour is generally considered to be a safe method and one which will not dull the edge.

Counting the time to raise the temperature in the hot air sterilizer to 320° F. and the one hour exposure at this temperature, the cycle should not take over one and one-half to two hours. If your cycle takes longer than this, something is wrong with your equipment or your procedure. You should call in a serviceman from the manufacturer of the equipment and ask him not only to check the sterilizer equipment but also instruct the nurses in proper procedures.

4. The Joint Commission on Accreditation of Hospitals has no specific requirements on this phase of your work. They check for above-normal incidence of postoperative infections and for evidence that your laboratory is making regular checkups on sterility of all things you sterilize.—E. W. JONES.

Releasing Hospital Records

Question: Frequently our hospital or pathologist gets requests to release tissue reports and other laboratory reports on former patients who are now in other hospitals or under the care of other physicians. What are the requirements for releasing such information—of course, only to other physicians or hospitals?—A.C.C., Pa.

ANSWER: Hospital records are protected in law by the rule of privileged communications, because it is held that a physician is unable to administer adequate treatment to a patient without full disclosure by the patient of information relating to his condition. Apart from legal requirements, sensible procedure dictates that hospitals and physicians should respect the confidential nature of all information obtained from patients and in examination and treatment of patients. Copies of pathology and other laboratory reports should not be released, under any circumstances, without the patient's permission. To prevent complications, the permission should be obtained in writing from either the patient or, in the case of a minor child, the patient's parent or legal guardian. Some authorities hold it is further desirable to have the signature on such written request witnessed by a responsible party to assure its authenticity, and for the patient's physician to be advised before any such reports are forwarded to other hospitals.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Interpreting Necropsy Report

Question: On one or two occasions in the past, we have had requests from the family for information about the necropsy findings on patients who have died. Is it proper for us to release the pathologist's findings to the family under these circumstances? Since these are, of course, written in technical terms that would not be understandable to the average layman, is it proper for us to provide an interpretive summary of the findings for the family?—S.T.J., Idaho.

ANSWER: Such requests should be referred to the patient's physician for interpretation. If the family should insist on having a written report from the hospital, it would probably be wise—in view of possible legal complications at some later time—to present only the factual findings as determined by the pathologist, and to suggest that this report be taken to the family's own physician for interpretation.

Standards in the Nursery

Question: Our newborn nursery is in an old building, and since a new pediatrician joined our staff recently, he has complained that control of temperature and humidity in the nursery is not up to accepted standards. What are the requirements?—P.W., N.Y.

ANSWER: First, you should know that the nursery conditions meet the infant care regulations of your city, county and state health departments. In addition, the American Academy of Pediatrics recommends that temperature and humidity in the infant nursery be maintained at the following levels: full-term nursery, temperature 75° F. and relative humidity, 60 per cent; premature nursery, temperature 75° to 80° F., relative humidity, 55 to 65 per cent. The thermometer in the nursery should be installed at approximately the level of the bassinets to permit proper temperature control. If the temperature is not constant, heat loss at windows and doors should be studied, and insulation or heating equipment improved to the point where it is possible to maintain the desired constant temperature and humidity.

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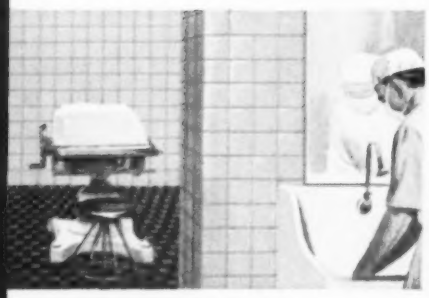
1. Nurses' Utility Rooms

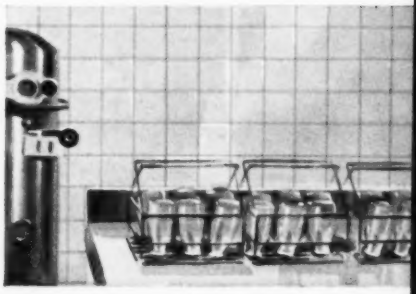
In hospitals . . . five key areas need tile



2. Operating Suites

3. Food Preparation Areas

4. Delivery Rooms



5. Infants' Formula Rooms

Swift, inexpensive sanitation and colorful permanence are benefits you get wherever you use American-Olean ceramic tile. In five key areas, these advantages—and others—are especially important.

In nurses' utility rooms and food preparation areas, resistance to stains make tile essential. Because its surface and color withstand frequent scouring with harsh disinfectants, tile is preferred for operating suites, delivery rooms, and infants' formula rooms.

American-Olean Conduct-O-Tile, which safely dissipates dangerous accumulations of static electricity, eliminates the main threat of anesthetic explosions in operating suites.

Free booklets give you valuable suggestions. Booklet 900 "New Large Size in Glazed Tile". Booklet 600, "Tile for Hospitals", includes color photos of many tile installations. Booklet 506 supplies more facts on Conduct-O-Tile. Send for your copies today.

Main Illustration: Utility Room, North Penn Hospital. Lawrie and Green, Architects. Color Plate No. 351. Walls: 19 Bluet and 83 Honeysuckle. Base: 21 Cornflower. Floor: Block Random, Cascade with Buff squares.

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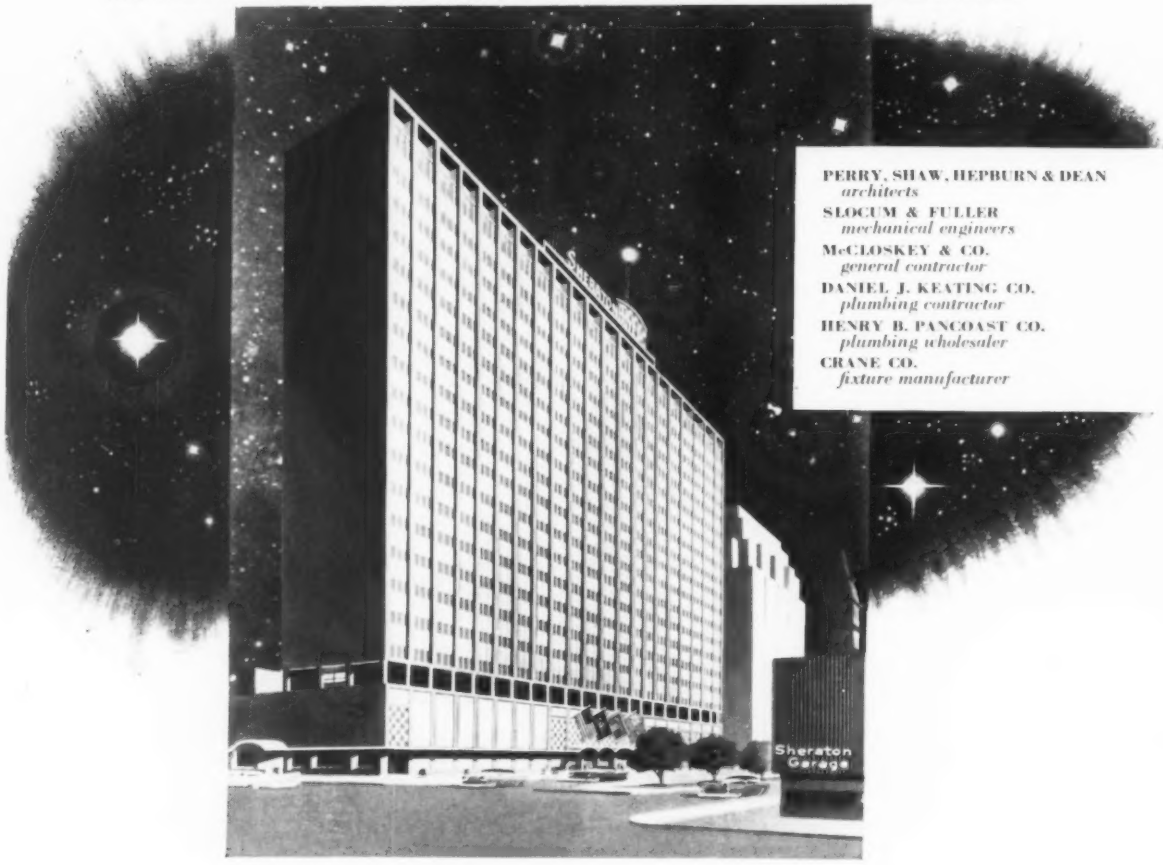

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• In Philadelphia this 1000-room, $16-million hotel is the 46th in the far-flung Sheraton galaxy, and the first to be erected by this famed chain in its 20-year history. This new Sheraton star is distinguished by a handsome exterior that heralds the functional beauty and air-conditioned comfort to be enjoyed inside. The spacious lobby is faced with golden-veined white Italian marble and Venetian mosaics. On the floor above is the superb Grand Ballroom; also the elegant main dining room, Town Room restaurant and smart cocktail lounge. On the third floor is the ballroom balcony and the uniquely decorated function rooms. All guest rooms have a wall-of-glass window overlooking the city. Many rooms are studio type, convertible into sleeping rooms at night. On the top floor are luxurious Executive Suites with private outdoor terraces. A 1000-car garage is accessible from the lower concourse. As are thousands of other expertly planned buildings, the new Sheraton is fully equipped with SLOAN *Flush* VALVES.

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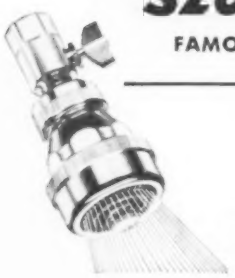

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

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wire from Washington

MEDICARE

With the Defense Department's dependent medical care program in operation for almost half a year now, it is possible to reach some fairly firm conclusions as to cost. The army's Office of Dependent Medical Care, which handles the operation for all services, reports the following, based on the first full five months of Medicare:

Civilian hospitals have sent in 36,922 billings, for a total of $3,562,297, or an average case cost of $96.48.

Physicians have filed 53,802 claims for a total of $3,583.40, or an average bill of $68.15.

Air force families lead others in use of Medicare. Of all claims, 41.5 per cent are from air force dependents, 32.5 per cent from navy, 23.7 per cent from army, and 2.3 per cent from U.S. Public Health Service.

Maternity care is accounting for 37.9 per cent of all cases, and tonsillectomies, next numerically, for 17.4 per cent.

With a significant number of cases available for analysis, the army found that when variable regional costs are taken into account, Blue Cross and Mutual of Omaha claims are almost the same. It costs the government $20.86 per day for patients handled through Blue Cross, and $18.78 for those serviced through Mutual of Omaha.

On a nonprofit basis, Mutual of Omaha services 14 Midwestern states, Florida, Georgia and South Carolina, while Blue Cross is in charge of the rest of the country, as well as Alaska, Puerto Rico and Hawaii, for hospital care. In reference to the $2.08 per day higher average for Blue Cross, the army points out:

"Figures compiled by the American Hospital Association in the yearly Guide show that it costs $2.23 a day more to care for a patient in the geographic area serviced by Blue Cross than it does in the Mutual of Omaha area."

The margin between Blue Cross and Mutual of Omaha's claims, based on a large number of cases, bears out the theory expressed by some officials a few months ago, when fragmentary data indicated that Blue Cross costs were much higher.

HOUSING LOANS

American Hospital Association is moving ahead with a plan that promises to make available to hospitals long-term, low-interest loans for building housing units for interns and student nurses. The problem is this:

In theory hospitals are entitled to Hill-Burton grants for building living quarters of this nature, but in almost every instance the project has or would have so low a priority as to make a grant impossible.

If the hospital is part of a college, it is eligible for Federal Housing Administration long-tem, low-interest loans for intern and student nurse housing, but this favorable financing is denied to hospitals without college affiliation.

Kenneth Williamson, head of the A.H.A.'s Washington office, appeared before a Senate banking and currency subcommittee to ask (a) that F.H.A. be given the authority to grant loans to hospitals not affiliated with colleges for intern and student nurse housing, and (b) the earmarking of $150 million in F.H.A. money for this purpose.

In testimony before the subcommittee, A.H.A. argued that the lack of living quarters for interns and student nurses was a serious obstacle to the training of enough physicians and nurses.

Accepting the A.H.A. arguments, the subcommittee, under chairmanship of Senator Sparkman, approved the new authority to aid noncollege hospitals, but it earmarked only $25 million in F.H.A. funds, rather than the $150 million asked by A.HA. Later the full committee approved the subcommittee's work.

The legislation is in the form of an amendment to a general housing bill that already has passed the House. Senate passage of the bill and amendment is expected. The question then will be whether the House will accept the Senate's idea on intern and nurse housing loans.

Rate would be 2⅞ per cent, and payment could be stretched over as many as 40 years.

TECHNICIANS' UNION

The Office Employees International Union, a well established (12 years old) autonomous union within the A.F.L.-C.I.O., is sponsoring the nationwide organization of medical and x-ray technicians for collective bargaining purposes.

Heading the organizing drive is J. Howard Hicks, secretary-treasurer of O.E.I.U., from his Washington headquarters.

Mr. Hicks said for the time being O.E.I.U. is footing most of the expenses, and all details of the campaign are handled through the Washington office. He explained that at this stage it would be unwise to identify those persons who are working to sign up technicians locally or regionally, as they might be subjected to "pressure."

According to Mr. Hicks, there is "widespread" interest in the new movement, and he is confident it will grow into a strong national union, in a position to negotiate on wages, hours and working conditions for medical technicians. Also, he said that reports from around the country indicate technicians are anxious for a more realistic appraisal of qualifications and job titles. The new union would assist in working these out.

(Continued on next page)

DOCTOR DRAFT

Although Congress is moving at a deadly slow pace on most health-medical bills, one in that field is just about certain to be passed before July 1. This is the bill to set up a new system for procurement of doctors for military service after the special doctor draft act expires June 30.

The procedure was worked out in what promises to be its final form during two busy days of hearings before the House armed services committee.

Basically, the problem is that the military services need physicians and dentists in a higher proportion than they appear in the general population. Under Selective Service rules, there can be no discrimination and men must be called only in age groups. Thus, to get the number of physicians and dentists needed, the armed services would also have to call up thousands of men they have no use for.

The solution in the original doctor draft was to make all physicians eligible for duty up to age 50 (later dropped to 46), but with definite priorities in which they would have to be called.

The new legislation follows the same pattern, but adopts the regular draft act's age limit of 35 years for men who have been deferred for educational reasons. Also, instead of standing alone as did the special doctor draft, the new one will operate as an amendment to the regular draft act.

Although Defense Department prepared its own bill, the House committee was dissatisfied with it and drew up a separate version. This is the one that now is moving rapidly through Congress. There are two main differences in the two versions:

1. **Whereas the department's bill** would drop the national, state and local advisory committees to Selective Service (at the request of Selective Service), the committee's bill continues them. The national committee is headed by Dr. Howard Rusk.

2. **The department's bill** does not continue various protective features written into the doctor draft act from time to time, such as the right of a doctor to resign his commission after completing his tour of duty; the committee's bill continues all of these provisions.

A by-product of the hearings was decision by the committee to voice strong disapproval of a Defense Department plan to increase the ratio of physicians to troops from 3 per 1000 to 3.4 per 1000, starting July 1. In effect, the committee told the military that when a special draft act has to be continued to obtain the doctors needed, there is no excuse for increasing their numbers beyond a bare minimum.

H-B FUNDS

Another bill—important to some state hospital programs—that is likely to be enacted any time now extends the time limit for using up federal money allocated to states for surveys and planning under the Hill-Burton amendments.

In 1954 Congress amended H-B, authorizing a special appropriation for grants for building diagnostic-treatment centers, hospitals for the chronically ill, rehabilitation facilities, and nursing homes. At the same time Congress voted $2 million to help states survey their needs for this construction, but stipulated that the states would have to use up the allocated money by July 1, 1957, or forfeit it. The new bill, by Senator Edward Thye (R.-Minn.), would give the states two more years to spend their share of the planning money.

Another Hill-Burton bill, one that would permit loans instead of grants at the option of the hospital involved, has some chance of action, but there is no indication that the bill to forbid H-B grants to any but public hospitals is being taken seriously by the committee.

V.A. PAY

The 4600 physicians, 785 dentists and 636 nurses in Veterans Administration posts are looking longingly toward Rep. George Long (D.-La.), himself a dentist, who is pushing a bill to give them all pay raises.

Except for the general economy pressure, the bill would make progress, mostly because it would help V.A. to obtain and keep professional personnel. The pay raise is not Rep. Long's idea alone. He drew it up on instructions from the full committee. It will be reported out of the committee promptly if House leaders will give it the green light.

Some of the provisions:

1. **Fifteen new positions** titled deputy assistant chief medical directors would be created.

2. **Optometrists** would be elevated in stature and probably paid on the same scale as physicians.

3. **The 25 per cent pay premium** allowed specialists would be cut to 10 per cent, but it could be applied until total salary reached $15,620 (under the present system maximums are much lower).

4. **The nonphysician hospital managers** (currently 46) would receive the same pay and grade as physicians in the same posts ($13,015 to $14,200).

5. **Increases for the top three grades** all would be $1700 per year, with smaller but substantial increases all down the line.

6. **Dentists** would receive the same rates and increases as physicians.

NOTES:

Small Business Administration has granted long-term, low-interest loans to three nursing homes and a hospital, the money coming from a deficiency appropriation enacted this year. Recipients are Hocott Memorial Home, Little Rock, Ark., $50,000; Farragut Nursing Home, Brooklyn, N.Y., $50,000; Buffalo Hospital, Buffalo, Okla., $33,000; and Alondra Nursing Home, Gardena, Calif.

Although Rep. Thomas Jenkins (R.-Ohio) **reports that** thousands of messages have reached Congress urging passage of the Jenkins-Keogh act, the House ways and means committee has not scheduled a hearing. The bill would allow certain income tax advantages to encourage the self-employed to set up their own pension plans.

Because residencies in physical medicine and rehabilitation generally are for three years, Secretary Folsom is asking Congress to add one year to residency grants; in passing the law in 1954 Congress set a two-year limit on federal assistance.

Starting July 1, the air force is offering residency training in general practice at its hospitals at Lackland Base, San Antonio, Tex., and Maxwell Base, Ala. The residencies have been approved by the American Medical Association and the American Academy of General Practice.

During the first quarter of the year, the U.S. released to states $60 million in surplus property; hospitals, schools and civil defense programs are among the recipients. Of the total $3 million was in real estate, the rest in such items as laboratory equipment, school and office supplies and furniture, and motor vehicles.

A. H. A. HEADQUARTERS TO GO 12 FLOORS

Approved by delegates at special meeting, 12 story building will be financed by 50 per cent, four-year dues increase; campaign for contributions from industry deferred for study

CHICAGO. — **After bouncing up and down like a rubber ball for two and a half years, the proposed new headquarters building of the American Hospital Association came to rest last month on the 12th floor.**

The decision for a 12 story building was made at a special meeting of the association's House of Delegates here May 18, when delegates voted to:

1. **Abandon a proposed nationwide campaign for contributions from industry.**

2. **Authorize the board of trustees to make contracts for completion of a 12 story headquarters building.**

3. **Amend association by-laws to increase dues 50 per cent for the years 1957 through 1960** for all members except personal members, hospital auxiliaries (Type V), hospitals under construction and foreign hospitals (Type VI).

4. **Interpret the temporary dues increase as outside affiliation agreements with state hospital associations,** so that the entire amount of the increase will be retained by A.H.A.

The key vote came on a motion to amend the by-laws and was taken by roll call. With a two-thirds majority needed to effect amendment, the motion was carried by a vote of 65 to 15, with 11 votes to spare.

The by-law amendment was revised **to provide for a temporary** dues increase for four years, instead of a special assessment in the same amount for the same period, it was explained, because it was believed some county, district and other government hospitals might encounter legal obstacles to paying an assessment.

The amended by-law provides that if the dues and temporary dues increase are not paid within 60 days of the date on which they become due and payable, "the director shall notify each member in arrears, and if said dues and temporary dues increase are not paid within 60 days thereafter, all privileges of membership shall be suspended until all arrears are paid in full."

By a separate vote, with one delegate dissenting, the House exempted personal members, hospital auxiliaries, hospitals under construction and foreign (but not Canadian) hospitals from the dues increase.

The 12 story building will cost $6,900,000 for construction, based on current bids, President Albert W. Snoke told the delegates. Estimated total move-in cost is $7,851,900.

Financing plans include a loan of $1,150,000 in addition to $2,300,000 in loans already negotiated for the five-story building now under construction, Dr. Snoke explained.

The 12 story building will have approximately 65,000 square feet of usable space, compared to 30,000 feet in the present headquarters offices, 43,000 feet in the five-story building and 95,000 feet in the proposed 17 story building, it was reported.

The decision to get off at the 12th floor and pay the entire bill out of association resources, without asking for outside contributions, resulted from widespread opposition on the part of member hospitals to the proposal for a fund raising campaign, and the feeling expressed by many members in state and regional meetings during the last two months that the 17 story building proposed by the trustees and approved by delegates at a special meeting March 16 was too ambitious.

When it became plain that members wanted no part of the fund raising campaign, which was expected to produce $4,700,000, the upper stories of the building began to disappear in a fog of uncertainty. On the basis of conservative forecasts of income and expense for the years ahead, trustees came to the conclusion that the building should be cut back to 12 floors.

While the fund raising campaign has been dropped as a part of the association's immediate financing plans, trustees will continue to study its feasibility and report to the House of Delegates again in September. Calls on industrialists had revealed lack of knowledge or interest in A.H.A., indicating the need for intensive preparation and education before a fund raising drive could be successful, Dr. Snoke said.

The 12 story building will provide four floors for rental to allied organizations, it was explained, and the financing contemplates rental income of $120,000 a year from this space. Financing estimates also allow for a 10 per cent loss of membership as a result of the dues increase, John Sullivan, association controller, said.

Some loss of membership is to be expected, it was indicated during the discussion. Speaking for Alabama, Delegate John Howell said in a prepared statement that there were many hospitals in his state which were "unalterably opposed to the 50 per cent assessment" and had raised the question of continued membership.

Reporting for Pennsylvania, Delegate Charles S. Paxson Jr. of Philadelphia said that only 15 per cent of 220 Pennsylvania hospitals had agreed to go along with the original proposals. Sixty hospitals voted unequivocally

against the proposals in regional meetings, he reported; 33 threatened withdrawal and another 25 might possibly withdraw.

What would happen now that the proposals had been modified was anybody's guess, but it was obvious that the compromise move had softened the opposition and that some, at least, of the threatened drop-outs would be retained. "You have taken some of the wind out of our sails," Montana Delegate George F. Pendergrast said frankly. "I'm not sure what the hospitals of Montana would say now," he added.

After pointing out that the small hospitals in Montana had struggled to meet the last dues increase, Mr. Pendergrast said he had been instructed to vote "No" on the original proposals and would also vote against the modified plan.

Several other delegates dropped their objections into the void between the 12th and 17th floors and voted for the modified program. In a meeting last month, the California Hospital Association had recommended that expansion be restricted to six stories to meet present needs, Delegate George Wood of Oakland reported. With the fund raising campaign, which California also opposed, eliminated, he voted for the new program. So did Delegate Clyde Fox of Nevada, another outspoken foe of the original fund raising plan.

Instructed to vote "No" on the original proposition, Delegate Henry H. Hill of Colorado interpreted his instructions as binding but urged other delegates to vote "Yes" on the 12 story plan.

Apprehension about the ability of many Canadian hospitals to pay the increased dues was expressed by Alberta Delegate S. V. Pryce of Calgary and Manitoba Delegate A. K. McTaggart of Brandon. Canadian hospitals feel they do not benefit from A.H.A. services to the extent U.S. hospitals do, Mr. Pryce reported. Of the plan for expansion he said ruefully, "We like the program—we just don't want to pay for it!"

Most criticisms of the way association staff, officers and trustees have managed the building project were abandoned on the nonexistent 17th floor and never found expression in the meeting. Notable exception was a curious statement read by Delegate Howell at the request of the Alabama Hospital Association—a schizophrenic document which lambasted officers and trustees for their "unrealistic and overambitious approach to the original building," suggested that the effort to inform members during the last 60 days was prompted by a desire to "share the blame for drastic and inexcusable errors of judgment," expressed "great misgiving and fear of the trend toward control by a few who wish to dominate," and then, in an astonishing reversal of form, said that "Alabama institutions acknowledge and commend the A.H.A. for all their past work and wish to say, 'Well done!' "

The statement then instructed the Alabama delegate to cast an affirmative vote but warned that it was not a vote of confidence for past actions.

Rough as it was in spots, the Alabama jeremiad sounded like a benediction alongside some of the things that were said about A.H.A. management during the debates that were held while the 17 story proposal was still under consideration, prior to the May 18 meeting. One memorandum that was widely circulated, for example, charged that the original building program was ill conceived and the membership inadequately informed, and that "the record of mismanagement subsequent to 1954 is demonstrable proof of the impracticality of the original program and calls for a vote of no confidence in association leadership."

For the most part, however, discussion of the propositions at state and regional meetings during the period between delegates' sessions related to the wisdom and practicality of the building and financing programs, and the charge of mismanagement was not widely credited. "Everybody has been friendly and polite to me, even if opposed," said Dr. Snoke, who attended a number of meetings to discuss the building plans with members. "I concluded that the membership is proud of the American Hospital Association and its accomplishments and stature and is anxious for these to increase."

At the conclusion of the May 18 meeting, Dr. Snoke and Past President Ray E. Brown of Chicago, who presided most of the time, agreed that the debate had been wholesome for the association, giving officers and trustees a better understanding of membership needs, and providing members with an opportunity to take part in the decision making process.

"The discussion not only results in an adequate headquarters building for the association," Mr. Brown said, "but it gives us a stronger association, with better understanding. As an officer of the association, I accept a full share of responsibility and offer my apologies for the extended negotiations that have been necessary in this project. But I have no apologies to make for the officers and trustees, who acted in good faith throughout the negotiations."

Relaxed on the 12th floor, the delegates closed the meeting by approving a resolution, introduced by Kenneth Wallace of Oklahoma, regretting the "inaccurate and incorrect manner" in which some actions of the board of trustees were reported and discussed during the building debacle and praising officers, trustees and staff for their "honesty, integrity and competence."

The motion was passed without dissent.

How Delegates Voted on A.H.A. Dues Increase

HERE is an unofficial summary of how delegates attending the special meeting of the American Hospital Association's House of Delegates May 18 voted on the by-law amendment to provide a temporary dues increase of 50 per cent from 1957 through 1960 to finance construction of the 12 story headquarters building on Lake Shore Drive:

For the increase: Officers Snoke, Terrell, Brown and Hatfield; Trustees Masur, McNary, Msgr. Smith, Aita, Harmon, McIntyre, Dunks, Holmes and Swanson; Delegates-at-Large Hahn, Wilson, Porter, Rankin, Hanson and Peel; delegates from Alabama, Arizona, Arkansas, California (2), Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois (2), Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts (2), Michigan (2), Minnesota, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio (2), Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas (2), Utah, Vermont, Washington, Wisconsin (2), Alaska, Quebec.

Against the dues increase: delegates from Colorado, Kentucky, Maine, Montana, Nebraska, New Hampshire, New Jersey (2), Pennsylvania (3), Virginia, West Virginia, Wyoming, Alberta.

Abstaining: Type IV Delegates Dabney and Webb; the Manitoba delegate.

The Modern Hospital
JUNE 1957

LOOKING AROUND

Desk Check

AS ONE who peers out at the world from behind huge stacks of books, reports, manuscripts, letters and miscellaneous papers, we have always felt an envious awe of that paragon of administrative efficiency, the Clean Desk Man. Administrators who keep their desk tops free of office debris, we have always thought, must be highly organized and instantly decisive. Unquestionably, their affairs are as tidy as their desks.

By today's standards, however, the Clean Desk Man is no longer the one to be admired and emulated by us lesser types. As a symbol of executive virtue he has been replaced by a superior species—the No Desk Man. A few days ago, a hospital administrator we know told us about his new office, a cozy affair with couches, easy chairs, draperies, planters and a conference table—but no desk.

"Why should an administrator have a desk?" our friend asked. "He spends most of his time talking to people, and a desk is just a barrier between them.

"Paper work is for assistants and secretaries," our man declared.

In administration as in everything else, apparently, the old standards are doomed, and instead of judging a man's importance by the size of his desk, as we used to do, we shall have to put him down as a slave to routine if he has a desk at all.

Even an administrative genius, however, cannot free himself entirely from the paper chains that bind us all. There is one task, our friend acknowledged, that he still performs himself, borrowing a corner of his secretary's desk for half an hour every week. We asked what this was.

"Signing checks," he said.

Muddy Road Ahead

A RECENT issue of *Chart,* official publication of the Illinois Nurses Association, reported that nurses at one Illinois hospital had obtained important salary increases following negotiations with the administration. "The new salary schedule represents a $50 per month increase as well as substantial improvements in shift differentials, overtime and holiday pay," the report said. Then it added:

"In order to encourage INA membership the policy of a salary penalty for nonmembers was announced. Salaries for nonmembers will be $10 less than for nurses in good standing."

This looked so much like a union shop clause that we asked a nurse acquaintance what was going on.

In reply, she showed us another report about another hospital where nurses were denied raises until they joined the American Nurses Association. The rule was made by the nursing office, it turned out. One nurse said, "The director of nursing told me my salary increase as head nurse would begin as soon as I showed her my receipt from the American Nurses Association."

What *is* going on? Are these isolated cases of overzealous membership activity by individual nurse executives, or is it going to be the policy of nurses associations to involve hospitals in a clout on nonmembers? In one of these cases, at least, the association reported calmly that the salary penalty for nonmembers was adopted to "encourage membership"—a term that falls somewhat short of describing the true situation, like a holdup man who says "Please."

Happily, it can be predicted with confidence that this compulsory membership movement isn't going to get very far, because hospitals are the principal employers of nurses, and not many hospitals will be whipsawed into permitting this kind of discriminatory salary differential among nurses. Even if some hospitals should fall into line, as a few have apparently done, this closed shop concept in nursing is bound to fail eventually, because the good end of more economic security for professional nurses can never be sought successfully by the bad means of heavy-handed labor union tactics.

As skilled and devoted professional people, nurses are certainly entitled to better salaries and working conditions than they have often earned in hospitals, the way things have turned out. But if the road to economic security for nurses lies through the union shop,

they'd better look for a detour. The union road is muddy, and nurses can't follow it without getting their uniforms dirty.

Friend

A RECENT public statement by Dr. Carl W. Walter, associate professor of surgery at Harvard Medical College and an outspoken authority on operating room asepsis, drew indignant replies from several hospital administrators. Dr. Walter charged that there are sharp increases in the incidence of postoperative infections in hospitals, caused in part by "poor sanitation" on operating room floors.

Replies came quickly. "Everything in the world is done to safeguard surgery patients," said one hospital authority. "Today's technics in operating and delivery rooms are better than ever before," said another. Others denied there has been any increase in the infection rate.

Disputes about facts, presumably, can always be settled by finding out what the facts are, and we don't intend to take sides in the argument between Dr. Walter and his critics—except, perhaps, to warn the latter that the former has always been a formidable man with a fact. We will argue, however, with one critic who said, "I can't understand a newspaper that would print a story such as that," referring to the original statement by Dr. Walter.

In our view, newspapers are serving society and hospitals well when they print a critical statement about hospitals by a responsible hospital authority. We do not share the alarm of some who fear that public confidence in hospitals is seriously undermined by an occasional critical article about hospitals in the newspapers. Hospitals and medicine generally have an overwhelmingly favorable press, it seems to us, and enjoy a measure of public esteem that is accorded no other group in our society. If there is some slight loss of esteem when criticism appears, it is insignificant alongside the loss of freedom that would result if we had the kind of society in which public criticism of any group could be suppressed.

Commenting on the Walter episode, an Eastern newspaper called Dr. Walter a "hard-boiled friend" of hospitals. "How long is it since you've heard another profession subjected to this merciless kind of self-examination and criticism?" the newspaper asked in an editorial. "When did a distinguished automobile designer tell the industry it's building cars to kill people and instruct it how to stop?

"Name your calling, and see if you can name the hard-boiled friend to whom it can gratefully owe the debt medicine and hospitals owe their Dr. Walter."

However hard-boiled, any friend of hospitals is a friend of ours.

Salute

A FEW weeks ago Edward W. Gilgan, director of the Hurley Hospital at Flint, Mich., made what seemed like a sensible proposal to the Secretary of Defense. Why not use trained medical corpsmen as volunteers in civilian hospitals, he suggested, and give them reserve training credit for the time so spent?

"Thousands of men have been trained as medical corpsmen in the various branches of the service," Mr. Gilgan pointed out. "Their work has been widely recognized by the medical profession. They have done a tremendous job.

"Many of these men are still in the reserve corps. It should be possible for these men to volunteer certain hours of their time on weekends or in the evening to help alleviate the emergent situation in hospitals. Such a program would enable the individual corpsman to keep up with medical care and treatment of patients and receive reserve training credit for specified periods. Moreover, hospitals should be willing to pay the going rate for any additional hours the corpsmen might provide."

In due course, the Department of Defense responded to the suggestion. "While employment in a civilian hospital would provide reserve medical corpsmen adequate practical training in the care of the sick and injured," the department said, "technical and practical instruction in the various phases of military medicine and military duties would be lacking; therefore, such employment does not meet the criteria established for the awarding of retirement point credit to reservists so employed."

There was more than that to the reply, of course. Summed up, it said that there are differences between military and civilian medicine, so you can't train medical corpsmen in civilian hospitals.

Well, it would unquestionably be complicated, and there would have to be some added training of such corpsmen "in the performance of certain military duties inherent in the operational functions of their military units" —to borrow a rococo phrase from the Deputy Assistant Secretary of Defense, who has one to spare. But we still think the idea is a good one, and that it could be worked out. We think it would be good for the services, and the corpsmen, and the patients, and the hospitals, and the communities. Apart from certain military duties inherent in the operational functions of their units, corpsmen take care of sick people, and that's what we do in our hospitals. You can't salute with a bedpan.

Staffed

DURING the National League for Nursing convention here last month, a group of nurse executives was visiting informally, and the familiar problem of staffing afternoon and evening shifts came up. With many married nurses on hospital staffs, the group agreed, the afternoon shift is especially troublesome today.

"Many of our nurses are wives and mothers as well as employes," one nursing director said, "and they need to be home in the afternoons when their children come home from school and their husbands come home from work, wanting supper and attention."

They all acknowledged this was a problem. Then one director told how she had solved the problem at her hospital. "We simply moved our schedules up so the afternoon shift starts at six instead of four o'clock," she said.

Frowns around the table. "But didn't it cause a lot of complications and trouble to change all your schedules around?" someone asked.

"It sure did," the director said cheerfully. "But we staffed the afternoon shift."

Round-the-Clock Nursing or Self-Service: Patient Care Is Based on the Medical Need

By concentrating nursing where it is most needed and offering self-service facilities for ambulatory patients, Manchester Memorial Hospital hopes to reduce patients' charges by reducing hospital costs

JANE BARTON

"WHY didn't somebody think of this before?"

That was the immediate reaction of the first patients to enter the self-service unit of Manchester Memorial Hospital, Manchester, Conn., the day it opened—April 1.

The fact is that Edward J. Thoms, the administrator, had been thinking about a whole plan of Progressive Patient Care, of which self-service is a part, for a long time. But months of planning and consultation with the medical staff, the board of trustees, the nursing staff, and, indeed, everyone who might be even remotely affected, were required to translate the program from an idea bobbing around Mr. Thoms' brain into actuality.

Briefly, Mr. Thoms' idea is that Progressive Patient Care under which patients with their beds and belongings are moved from intensive to routine to self-service care, as their medical needs dictate, will result in reducing charges by reducing the costs of hospital service. Furthermore, he is sure that a much more efficient use of available nursing service can be achieved by concentrating the skills of the highly trained R.N.'s upon the critically ill.

In both of these beliefs Mr. Thoms has the support of the medical staff and the trustees. Dr. A. E. Diskan, chairman of the nine-man Special Care Committee of Manchester's medical staff, which has worked out the details of the program with the administrator, explained: "This was a new concept in hospital care—the only one that has ever been attempted that might diminish the cost of care rather than raise it. And we are going to save nurses by concentrating them where they are needed instead of scattering them."

Somewhat more cautiously, C. Elmore Watkins, president of the board of trustees, observed that Mr. Thoms' idea seemed "so logical to businessmen [the trustees] that it should appeal to the public."

ZONES OF CARE

As it has been worked out at Manchester, the Progressive Patient Care plan consists of three zones of care:

1. The Special Care Unit—27 beds, plus a lounge for the patients' relatives. In this section are concentrated the critically ill patients who require careful medical supervision and intensive nursing care. Within this unit 17 beds have been set aside (in three four-bed wards, one semiprivate and three private rooms) for patients who might be described as "super-critical" but not, Mr. Thoms emphasizes, moribund. He wants it clearly understood that "special care" is not to be equated with "terminal care." Patients assigned here are all those (except pediatric and obstetric) who can be expected to live, granted they receive intensive, devoted nursing care with all the necessary supplies, equipment and medications immediately available.

2. The Routine Care Unit—89 beds. This is just what its name implies. Patients who are graduated from the special care unit, as well as those who are just "normally" sick when they enter the hospital, occupy the routine care section. Naturally, it comprises the largest area of the hospital.

3. The Self-Service Unit—eight beds. This section, now located in a house across the street from the hospital, is the real pioneer project and Mr. Thoms' special pride, joy and headache. It is designed to care for patients who are well enough to take care of their own simple medical needs; to go to the hospital for their meals (except breakfast, which is served in their rooms), and also for laboratory and x-ray tests.

The self-service unit will not be populated solely by "graduates" of the special care and routine units. Actually, it is likely to be used more by patients who are in the process of being admitted to the hospital, undergoing tests, and so forth. Another thing it is *not*, Mr. Thoms emphasized, is a "rest home or a cheap vacation." Only a staff doctor can admit a patient into the unit. It is an integral part of the hospital, with all its responsibilities and duties to the patient.

The house contains eight attractively furnished single rooms, equipped with lavatory and toilet. (Having all rooms private overcomes the usual difficulties involved in assigning space to male and female patients.) On the first floor are a lounge furnished with television set, easy chairs, tables and reading materials; a short-order kitchen, and a small utility room.

A patient's progress from special care to self-service unit goes something like this: He receives concentrated medical care for an average of two or three days, when he is sufficiently improved to move along to an area of lesser specialization. At first this

SELF-SERVICE UNIT

DESCRIPTION

This suite consists of eight hotel-type rooms, well appointed with hotel furniture, lavatory and toilet in each room. (The establishment of private rooms alleviates the problem of male-female admissions.) A central lounge contains a television set, easy chairs, tables, and light reading materials. A short-order kitchen is available for snacks. A small utility room provides equipment for x-ray and preoperative preparation.

FUNCTION

One R.N. heads the unit with the help of an aide —and maid service is similar to that in hotel accommodations. All patients in the self-service unit take care of their own simple medical needs. All patients are ambulatory in relation to cafeteria meals, x-ray studies, laboratory examinations, and so forth. Routine instruction sheets are furnished the patients in regard to clinical studies to be carried out.

REMARKS

The admission of patients to this area is more or less experimental until common usage gives an evaluation of the types of patients best suited for self-service care. The final decision on the categories of patients admitted to this unit rests with the attending physician.

The location of the self-service unit must be such that it will discourage the possibility of acute admissions to this area. In this instance, it is situated adjacent to the hospital in a converted nurse dormitory and is thus properly separated from the rest of the hospital.

may be a continuation of care in the not-so-critical section of the special care unit, but as soon as his condition warrants it, he again moves on—this time to the routine care zone. From routine care he may either go home or, if he isn't quite ready to be discharged, to the self-service unit for a couple of days. For an eight-day stay, Dr. Diskan estimated that a patient would have three days of special care, three of routine care, and two of self-service care.

COSTS TO PATIENTS

Manchester Hospital officials hope that when the pattern of progressive care is finally evolved (it's still in the experimental stage, they point out), costs to a patient will be based on the kind of treatment the patient receives. As he moves from special to routine to self-service care, he should pay less and less. At present, the charge for the special care unit is based on the patient's "ultimate destination." That means that if he is a private patient who will occupy a $21 per day room when he can be moved to routine care, he pays $21 per day in the special care unit. If he is a ward patient, he pays the ward rate—and no more. Special care patients save money by receiving the best kind of "private duty" care without having to pay extra for private duty nurses.

The self-service unit offers opportunity for the most dramatic savings. Patients now pay $8 per day and, as more beds can be assigned to this area (when the projected addition to the hospital is built), Mr. Thoms is convinced that costs can be reduced still further since it will be less expensive to operate a unit for 16 patients, for example, than it is for eight. Eventually he hopes that as many as 30 to 40 per cent of the inpatients will be occupying beds in the self-service unit.

MEDICAL STAFF AND TRUSTEES

Establishment of the Progressive Patient Care unit was not just a matter of physical rearrangement of the hospital to provide space for the special care and self-service units. Mr. Thoms realized from the start—and it was borne in upon him increasingly as plans progressed—that the people involved in any such endeavor determine its success or failure. When people are convinced of the rightness of a project, they seem always to be able to work out the "things."

In this case, the people Mr. Thoms had to convince were the members of the medical staff and the trustees. The first group of doctors he approached—the nine-man committee referred to previously—was surprisingly enthusiastic. Dr. Diskan, Dr. Lane Giddings, the pathologist, and Dr. Howard Lockward, among others, could see all kinds of benefits in the project. They undertook to overcome any objections their colleagues on the staff might have —and they were sure there would be objections. There were.

Many of the doctors felt that the idea was too drastic a departure from the usual type of medical care; they were by no means convinced that their patients could get as good nursing care on the special care unit as they would with private duty nurses. Some thought that patients would object to the self-service unit on the grounds that they weren't "getting what they were paying for." Others thought that patients who had received intensive care in the special care unit wouldn't be satisfied with anything less when they were moved along to the routine unit; they'd be spoiled by it. Still another objection was that patients would resent being shifted from one unit to another.

The anesthesiologists could see the special care unit only as an encroachment on their beloved recovery room —and dug in their heels at the prospect of having it taken away from them. A compromise was reached on this issue. Although the large recovery room was, indeed, worked into the special care unit, a smaller postanesthesia room has been set aside for immediate postoperative patients until they are ready to be assigned to either special or routine care.

One by one, the objections were overcome and, always, Mr. Thoms and the special committee pounded away at the point that the doctor and only the doctor would dictate which patients were to be admitted to the various units, what kind of care they would

receive, when they should be transferred from one unit to another, and so on. It was emphasized that no doctor on the staff "had" to admit his patients to the special care unit and that nobody, patient or doctor, was going to be coerced into doing anything.

It took some high-powered salesmanship, plus one glorious barracks-room brawl, Dr. Diskan recalled gleefully, to get the medical staff solidly behind the program so that the board of trustees in turn could be persuaded of the feasibility of the idea.

The brawl took place after the meeting with the trustees to whom Mr. Thoms reported happily that the medical staff was "entirely in favor of the plan."

To his horror, he was informed, frostily, that the staff was nothing of the kind — that various doctors had called trustees to protest the idea. There was nothing for the administrator to do but call another meeting of the staff and find out how many doctors had been overcome with second thoughts and, most particularly, why they hadn't confided their worries in Dr. Diskan's committee and Mr. Thoms instead of the trustees. This time, they got it all straightened out.

Like the doctors, the trustees had some pointed questions they wanted to have answered before they were ready to go along with the project. They were not at all sure how the community would react. In fact, one trustee reported that a leading citizen had roundly denounced the whole scheme as "socialized medicine." Another fear was that patients in the self-service units might be injured crossing to the hospital. The trustees did not want the hospital to be thought negligent of the welfare of any group of patients even though they were considered well enough to get around safely by themselves.

Once they were convinced that their

SPECIAL CARE UNIT

NURSING ROUTINE

The following routine will be followed on all patients in special care unit having designated doctor's order—"S.C.U."

1. Departure from the routine will be by written order of a doctor.
2. Weigh patients daily, at same period each day.
3. Intake and output totals will be for a 24 hour period ending at 7 a.m. instead of the midnight to midnight schedule now employed.
4. Intake and output records (daily and summary) will be made and maintained accurately on *all* patients.
5. The volume, specific gravity, and pH will be taken and recorded on all urine specimens.
6. Each patient will be seen every two hours at which time the following will be accomplished:
   (1) Vital signs—pulse, respiration, and blood pressure — will be entered on appropriate form. Temperature taken and recorded every four hours.
   (2) Record volume of I.V. fluid run in during two-hour period.
   (3) Record the volume, specific gravity, and pH of urine for two-hour period if patient is on catheter drainage.

CHARTING

1. Daily and summary intake and output and vital sign forms will be kept by each bed. There is also a space on the vital sign forms for all nurses' notes and medications given which are to be entered at the appropriate time. These forms will become an official portion of the record when a patient is transferred from the special care unit. No other nurses' notes or vital signs are necessary. New daily Intake and Output sheets and Vital Signs forms will be added to the existing forms by the bedside daily. The old ones will be kept at the bedside.
2. Charting will routinely be done every two hours at the time of the nurse's rounds.
3. When an I.V. is started, the material in the I.V. will be written in under "Parenteral." Calibration slips will be affixed to each I.V. bottle, making it simple to mark off the calibration slip every two hours and thereby know and enter the volume of I.V. fluid run in during the two hours. This will be charted under "H_2O." When the I.V. is finished, enter the constituents of the I.V. in the proper columns, *i.e.* H_2O, calories, Na, and so on.
4. The same procedure will be used for "blood, albumin, and so forth."
5. Appropriate space is allotted for entering the two-hour urine volume, specific gravity and pH. A running total of the urine output should be entered under "Total," as in the present intake and output procedure.
6. Oral intake will probably be slight in this unit, but there is space provided for entry of oral intake on the form.
7. There is space on the Vital Signs form for the q. 2-hr. vital signs to be recorded, and also nurses' notes and medications as indicated.
8. Emesis volume and stool volume, if liquid, or a simple mark if solid, are entered in the proper columns as has been the usual practice.
9. The daily chart will be totaled at 7 a.m. at the bottom of the form.
10. At 7 a.m. the summary sheet will be filled in using the same figures from the daily total on bottom of daily Intake and Output chart.
11. Laboratory work will be entered by M.D.'s on the summary form.
12. A wall chart will list the constituents of the various I.V. solutions and added materials. (Electrolytes are in milli-equivalents.)

PATIENTS' COMMENTS ON SELF-SERVICE UNIT

"Crowell House is truly an ingenious idea to care for diagnostic patients as well as convalescents. The fact that no one staying at Crowell House is 'sick' in the true sense of the word means that everyone is in a cheerful frame of mind. Actually, I felt more as if I was on a vacation than a patient in the hospital!"

"There are one or two areas that require constructive criticism. First of all, I would strongly urge that immediate consideration be given to the installation of showers and/or bathtubs at Crowell House. Anyone who remains there more than two days would really appreciate the additional convenience. A second area of criticism concerns the cafeteria. Some of my meals were adequate, and some portions of those meals even good, but the average across the board left something to be desired."

"Crowell House is an excellent, progressive step in hospital administration; it is comfortable, pleasant and, even more important, economical beyond belief. Many thanks to you and your staff for the courtesy extended to me during my stay."

"Patients who were coming into the Crowell House for examinations were also saying what a perfect idea for the person who does not need a bed to lie in all day to await x-ray, etc."

PATIENTS' COMMENTS ON SPECIAL CARE UNIT

"As one of the first patients in your new special care unit, may I say, 'I approve'? Thanks again for making my stay as comfortable as possible."

"I cannot say enough about the wonderful care I received in the special care unit during my critical period of need. It is definitely the type of service a patient who has just been operated on requires to speed his recovery. I know that my own rapid progress was due to the attention I received in that unit, and then the following care I received from all three shifts."

PATIENTS' COMMENTS ON BOTH UNITS

"Your new intensive care unit and program are working to perfection as far as I am concerned. I was moved to the Crowell House for my two days of ambulatory care before coming home, and while there met others who were very pleased with the accommodations and courtesy extended."

"The administration should be highly commended on the wonderful routine given, especially the Special Service Unit where I really appreciated the special care given me. My last few days at the Crowell House were so enjoyable and everyone makes you feel right at home."

fears on all scores were groundless, the trustees rallied nobly around their administrator and voted to spend $14,000 for the remodeling of Crowell House, which had formerly been used as a nurses' residence, into the self-service unit.

During the planning, Mr. Thoms and some of the doctors visited various hospitals in the East which had inaugurated intensive nursing care units to learn how they were handled and what special problems had turned up in connection with them. At all hospitals they were cordially received and given an opportunity to find out how the doctors and nurses really felt about the units. In one institution they found that only about 12 out of 28 beds set aside for intensive care were actually being used because the medical staff was not at all sold on the idea. In another, the nurses had effectively quashed the whole project by walking out on it.

After each trip, the visitors returned to Manchester with new ideas—and the firm conviction that they were on the right track in working out an integrated plan of progessive care, rather than settling for just one special unit.

NURSING

Second only to the doctors in their importance to the project—and it could be argued that they are of equal importance—are the nurses. Several questions worried Mr. Thoms in regard to the nursing aspects of his program. The chief one was, of course, would the nurses stand for it at all? Nursing in the special care unit is arduous in the extreme and it takes a high degree of skill plus an instinct for doing the right thing at the right time and doing it fast. It is not everybody's dish.

Again, should nurses assigned to special care receive extra pay, or would there be repercussions? Who should be in charge of the unit and how much authority should she have? What would be her relationship with the doctors? Who would arbitrate in case of disputes as to whose patients should be admitted and whose should be transferred out of the special care section? How many nurses would be required to staff the special care unit and what should be the proportion of registered nurses to licensed practical nurses and aides? What about staff for the routine care and self-service units? The patients there have to have good nursing care, too, even if they don't need

(*Continued on Page* 56)

SPECIAL CARE UNIT

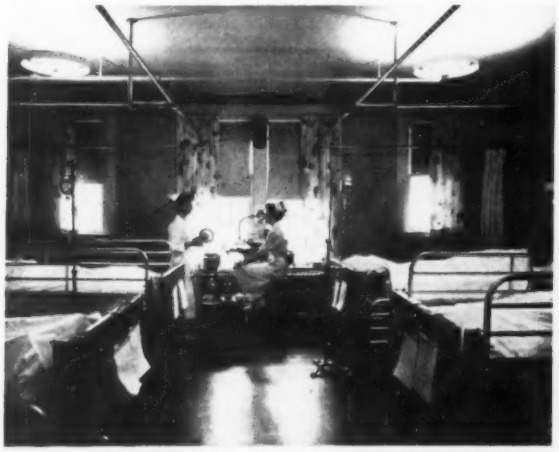
One of the private rooms in the "supercritical" section of the special care unit at Manchester General Hospital.

SELF-SERVICE UNIT

The patients in Crowell House make good use of the attractive lounge, equipped with TV set and comfortable chairs.

Special forms for the recording of daily intake and output and the vital signs are kept at the end of patient's bed.

Typical patient's room in the self-service unit. Each of the eight rooms is equipped with lavatory and toilet facilities.



Two nurses on duty in one of the four-bed wards of the special care unit, which has had a 90 per cent occupancy.

Nurse on duty at the nurses' station in Crowell House. A short order kitchen for snacks is shown behind her.

(*Continued From Page* 54)
the intensive treatment given to the critically ill.

As it turned out, he needn't have worried about a lot of those questions. Even without the lure of extra pay (which they do get) the nurses thought the idea was fine. They welcomed the chance to "do real nursing again," as some of them expressed it. One of the problems that faced Vera Dormer, the director of nursing, was how to select nurses to work in the special care division without hurting the feelings of those not chosen. Her choice for head of the unit fell upon Anne Gilbert, who has been on the hospital's nursing staff for 22 years. The selection met with approval all around. Like Mrs. Dormer herself, Mrs. Gilbert is a friendly soul who gets along fine with everyone, but can also put her foot down heavily when a heavy foot seems to be indicated.

Mrs. Gilbert, who is on duty from 7 a.m. to 3:30 p.m., has full charge of the floor and makes all arrangements when a doctor requests that a patient be admitted or transferred to the special care unit. After the patient is safely in his bed, the family goes to the regular admitting office to give his history and arrange for payment. If all beds are full and the case is emergent, the staff doctor and Mrs. Gilbert discuss the possibility of transferring another patient. This, of course, requires the permission of that patient's physician. If there is any question about whose patient goes or stays, the two staff doctors settle it between themselves or, it necessary, refer the matter to the chief of the respective staff section for decision.

All patients admitted to the unit are given the special nursing care outlined in the chart at the bottom of page 53. Special daily and summary intake and output and vital sign forms have been developed by Dr. Lockward to facilitate the record keeping. These forms, which are kept at the patient's bed, become an official part of his record when he is transferred to another unit.

The staffing pattern worked out for the 27 bed special care unit is as follows:

7 a.m. to 3:30 p.m.: Five R.N.'s, three aides, and one orderly.

3:30 p.m. to 11 p.m.: Five R.N.'s and two aides.

11 p.m. to 7 a.m.: Four R.N.'s and two aides.

The self-service unit is in charge of a registered nurse, with another R.N. for relief periods, from 7 a.m. to 3:30 p.m. On the evening and night shifts, a licensed practical nurse is in charge.

All of the nurses and aides selected for service in the special care unit were given an intensive training course by Mrs. Dormer before the unit opened. Nursing turnover being what it is, staffing will probably always be a problem but Mrs. Dormer and Mrs. Gilbert are confident that, one way and another, they will be able to keep the nursing group on the unit up to standard, both quantitatively and qualitatively.

WHAT HAPPENS NEXT?

Only time will tell how patients, their families and friends—and the community—will react to Manchester's Progressive Patient Care program, although the comments already received (some of which are presented on these pages) indicate that the reaction is generally favorable. Another index of the success of the program is the following résumé of the occupancy of both the special care and the self-service units since the opening and the types of cases cared for.

The special care unit has had an occupancy of 90.6 per cent in the supercritical zone, with 66 surgical and 29 medical cases. Surgical cases included hysterectomy, radical mastectomy, bowel resection, gastric resection, cholecystectomy, vaginal repair, splenectomy, thyroidectomy, groin resection, appendectomy, amputations, compound fractures, hip nailing, diaphragmatic hernia, ureteral lithotomy, transurethral resection, and nasal reconstruction. Medical cases were cardiac, pneumonia, acute pancreatitis, bronchial asthma, gastroenteritis, bleeding ulcer, exposure from water immersion, and G.U. bleeding.

The mortality rate on the unit has been very low. Three patients have died: one of congestive heart failure, one of coronary thrombosis, and one of cardiac decompensation with broncho-pneumonia.

The eight-bed self-service unit has had 84 per cent occupancy. Sixty-five patients were direct admissions to Crowell House; the diagnoses included abdominal pain, pyelitis, colitis, rectal bleeding, iritis, headaches, renal disease, gastritis, hip injury, fever, acute gallbladder, hypertension, lymphadenitis, and erythema nodosum. Transfers from the hospital numbered 16 patients. Of these, some were diabetics and the rest were recovering from ulcers, pneumonia, lacerated hand, cholecystectomy, herniorraphy, radical mastectomy, thyroidectomy, hysterectomy, and colon resection.

Mr. Thoms is firmly convinced that the medical staff will be the deciding factor. If the doctors believe in the program, they will be able to interpret it to their patients and persuade them of the benefits it offers. If they don't believe in it, the whole program will fall apart—"and if it's going to fail, we might just as well find it out now and forget the whole idea," he philosophized to a reporter.

Obviously, he doesn't think it's going to fail. On the contrary, he thinks that the Manchester plan properly carried out (and that means having the time and money to give it a fair trial) can have a significant influence on the design and equipment of hospitals, as well as on their administration and management.

Crowell House, the self-service unit of Manchester Memorial Hospital, was a nurses' residence. It was remodeled to house eight self-service patients and officials wish it were large enough to take care of sixteen.

Audit Shows Hospitals Where They Stand

This new method of organizing medical audits puts the evaluation of patient care on a practicable basis and gives a maximum of useful information for a minimum of effort

ROBERT S. MYERS, M.D.
VERGIL N. SLEE, M.D.

SINCE the beginning of written records, we know that man has found it necessary to establish standards of performance and to devise methods of measuring his attainment of these standards. In industry and finance he has been eminently successful in these endeavors; in medicine he has made relatively little progress throughout the centuries. This does not mean that physicians have not been interested in evaluating the results of their treatment of patients; ancient and modern medical literature abounds with accounts of the treatment of disease and the reasons for success or failure of such treatment. What it does mean is that methods for routine and widespread evaluation of the performance of physicians have lagged far behind other scientific achievements. Without exception, previous methods have been sporadic in nature, limited in scope, burdensome to the physician, and uninformative in content.

With the hope of devising a method that would be useful to the medical profession and hospitals in the continuing evaluation of patient care, the American College of Surgeons, in cooperation with the Commission on Professional and Hospital Activities, has been engaged since 1953 in a research program* to devise a practicable medical audit. The progress has been gratifying. The method has been tested and found entirely acceptable by the medical staffs of a pilot group of typical community hospitals, and the procedure has been sufficiently refined to permit its release to additional hospitals.

Dr. Myers is assistant director of the American College of Surgeons and treasurer of the Commission on Professional and Hospital Activities, Inc. Dr. Slee is director of the Commission on Professional and Hospital Activities, Inc.

*Supported by grants from the W. K. Kellogg Foundation, Battle Creek, Mich.

AUDIT METHOD ACCEPTABLE

Recently, following study, the College's medical audit method was judged by the Joint Commission on Accreditation of Hospitals as an acceptable substitute for part of the activities of the tissue and medical record committees, the functions of which are a requirement for accreditation.

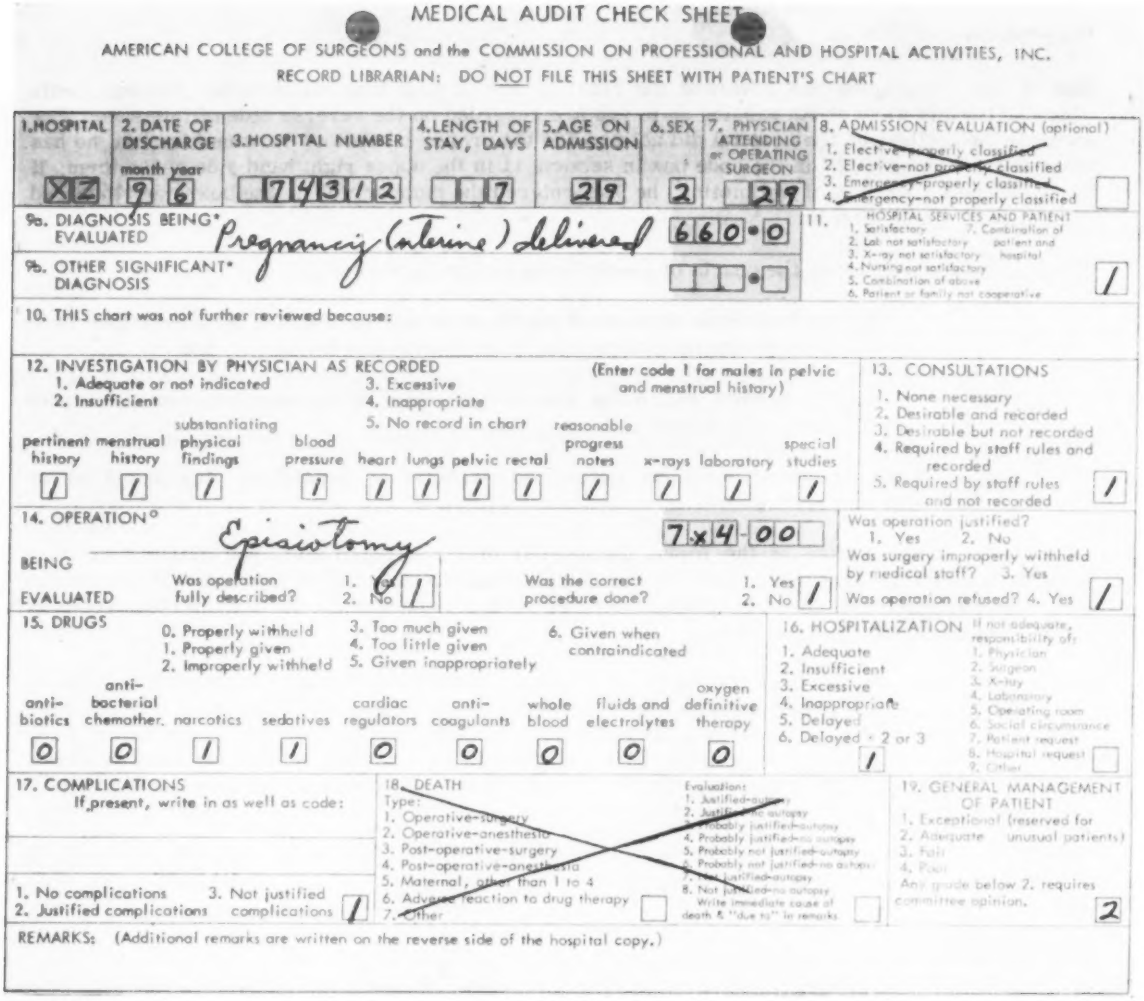
The research project demonstrated at an early stage that if a significant amount of medical auditing were to be done, the medical staff of each hospital would have to do it. Consequently, the method developed has been designed to permit the audit committee of a medical staff to perform an adequate evaluation of medical practices without placing an intolerable burden upon the committee and the other staff members who must do the auditing. The system developed by the College and the commission attacks certain problems important in this regard:

1. The staff must have an adequate statistical picture of its practice. The necessary statistical foundation is provided by the Professional Activity Study of the Commission on Professional and Hospital Activities, which supplies continuous statistical data to participating hospitals. In addition, the disease, operation, physician and surgeon indexes, provided by the P.A.S., abstract sufficient information from the clinical record to aid the audit committee appreciably in its evaluation of medical practices.

DON'T DISSIPATE STAFF ENERGY

2. A selection method must be used so that auditing energy of the medical staff is not dissipated. The system here employed takes into account factors known to be important, such as death, type of surgery, type of medical, obstetric or pediatric problem presented, and differences in practice among hospitals and physicians as detected by the Professional Activity Study.

3. The review of each clinical record must be rapid and efficient, yet order-



MEDICAL AUDIT CHECK SHEET

AMERICAN COLLEGE OF SURGEONS and the COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, INC.

RECORD LIBRARIAN: DO NOT FILE THIS SHEET WITH PATIENT'S CHART

1. HOSPITAL	2. DATE OF DISCHARGE (month year)	3. HOSPITAL NUMBER	4. LENGTH OF STAY, DAYS	5. AGE ON ADMISSION	6. SEX	7. PHYSICIAN ATTENDING or OPERATING SURGEON	8. ADMISSION EVALUATION (optional)
X Z	9 6	7 4 3 1 2	0 7	2 9	2	2 9	1. Elective-properly classified 2. Elective-not properly classified 3. Emergency-properly classified 4. Emergency-not properly classified

9a. DIAGNOSIS BEING EVALUATED: Pregnancy (interim) delivered — 6 6 0 • 0

9b. OTHER SIGNIFICANT DIAGNOSIS: • 0

11. HOSPITAL SERVICES AND PATIENT: 1. Satisfactory; 2. Lab not satisfactory; 3. X-ray not satisfactory; 4. Nursing not satisfactory; 5. Combination of above; 6. Patient or family not cooperative; 7. Combination of patient and hospital — 1

10. THIS chart was not further reviewed because:

12. INVESTIGATION BY PHYSICIAN AS RECORDED (Enter code 1 for males in pelvic and menstrual history)

1. Adequate or not indicated; 2. Insufficient; 3. Excessive; 4. Inappropriate; 5. No record in chart

pertinent history	menstrual history	substantiating physical findings	blood pressure	heart	lungs	pelvic	rectal	reasonable progress notes	x-rays	laboratory	special studies
1	1	1	1	1	1	1	1	1	1	1	1

13. CONSULTATIONS: 1. None necessary; 2. Desirable and recorded; 3. Desirable but not recorded; 4. Required by staff rules and recorded; 5. Required by staff rules and not recorded — 1

14. OPERATION BEING EVALUATED: Episiotomy — 7 x 4 • 0 0

Was operation fully described? 1. Yes 2. No — 1

Was the correct procedure done? 1. Yes 2. No — 1

Was operation justified? 1. Yes 2. No

Was surgery improperly withheld by medical staff? 3. Yes

Was operation refused? 4. Yes — 1

15. DRUGS: 0. Properly withheld; 1. Properly given; 2. Improperly withheld; 3. Too much given; 4. Too little given; 5. Given inappropriately; 6. Given when contraindicated

anti-biotics	anti-bacterial chemother.	narcotics	sedatives	cardiac regulators	anti-coagulants	whole blood	fluids and electrolytes	oxygen definitive therapy
0	0	1	1	0	0	0	0	0

16. HOSPITALIZATION: 1. Adequate; 2. Insufficient; 3. Excessive; 4. Inappropriate; 5. Delayed; 6. Delayed + 2 or 3 — 1

If not adequate, responsibility of: 1. Physician; 2. Surgeon; 3. X-ray; 4. Laboratory; 5. Operating room; 6. Social circumstance; 7. Patient request; 8. Hospital request; 9. Other

17. COMPLICATIONS: If present, write in as well as code:

1. No complications; 2. Justified complications; 3. Not justified complications — 1

18. DEATH: Type: 1. Operative-surgery; 2. Operative-anesthesia; 3. Post-operative-surgery; 4. Post-operative-anesthesia; 5. Maternal, other than 1 to 4; 6. Adverse reaction to drug therapy; 7. Other

Evaluations: 1. Justified-autopsy; 2. Justified-no autopsy; 3. Probably justified-autopsy; 4. Probably justified-no autopsy; 5. Probably not justified-autopsy; 6. Probably not justified-no autopsy; 7. Not justified-autopsy; 8. Not justified-no autopsy

Write immediate cause of death & "due to" in remarks.

19. GENERAL MANAGEMENT OF PATIENT: 1. Exceptional (reserved for unusual patients); 2. Adequate; 3. Fair; 4. Poor

Any grade below 2. requires committee opinion. — 2

REMARKS: (Additional remarks are written on the reverse side of the hospital copy.)

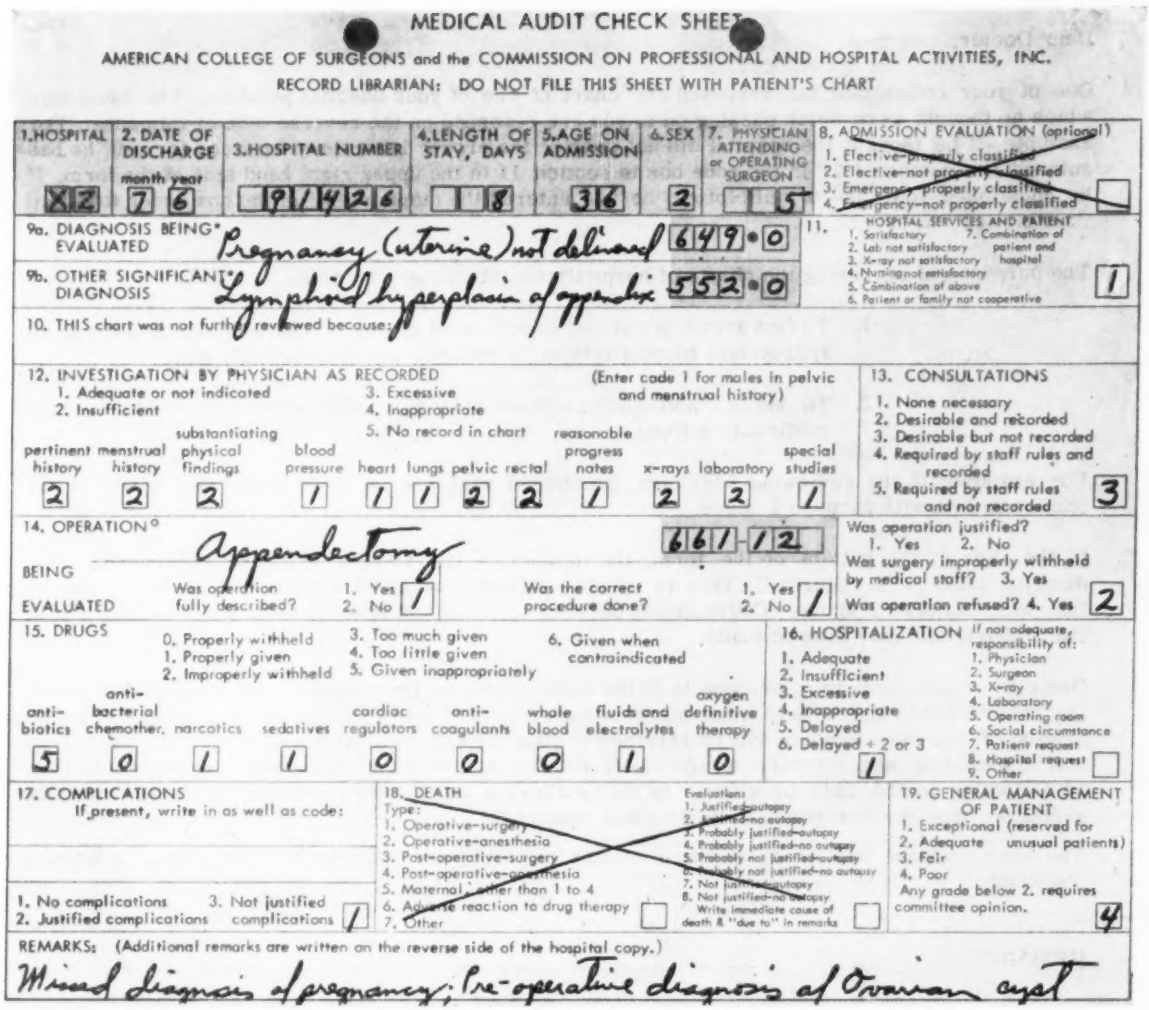
FIGURE 1

FIGURE 1 is a completed medical audit check sheet on which is recorded the evaluation of the care given a 29 year old female, who was admitted for delivery of an uncomplicated pregnancy. Note that the physician-evaluator records his findings by entering digits in the code boxes (□) on the form. For the most part, the codes employed are printed with the item under consideration. The care of this patient was considered adequate in every way. The investigation was complete as indicated by the 1's in the boxes in Item 12. Medications were given properly as evaluated in Item 15. Item 14 records that an episiotomy was performed with proper indications. The case did not require consultations (Item 13), the hospital services were satisfactory (Item 11), the hospitalization of seven days (Item 4) was adequate (Item 16). No complications arose, and the general management of the case was considered adequate.

Items 1 through 7 and the codings in Items 9 and 14 (the shaded areas of the form) are completed by the medical record librarian since these are factual data not requiring the judgment of physicians. All other items are completed by the physician-evaluator. It should be noted that the patient is identified only by the hospital number, which is confidential within the hospital, and that the physician is identified by a code known only to himself and to the chairman of the hospital's medical staff audit committee.

ly and thorough. To meet this need a "Medical Audit Check Sheet" has been devised (see Figs. 1, 2 and 3).

4. The clerical burden on the physician must be minimal. The medical audit check sheet, providing as it does for simple coding of the necessary information, solves part of the problem. In addition, certain coding and control are delegated to the medical record librarian, while the tabulation of the audit committee's findings and preparation of permanent records are done by punch card methods in the offices of the commission in Ann



MEDICAL AUDIT CHECK SHEET

AMERICAN COLLEGE OF SURGEONS and the COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, INC.

RECORD LIBRARIAN: DO NOT FILE THIS SHEET WITH PATIENT'S CHART

1. HOSPITAL	2. DATE OF DISCHARGE (month year)	3. HOSPITAL NUMBER	4. LENGTH OF STAY, DAYS	5. AGE ON ADMISSION	6. SEX	7. PHYSICIAN ATTENDING or OPERATING SURGEON	8. ADMISSION EVALUATION (optional)
X Z	7 6	1 9 1 4 2 6	8	3 6	2	5	

9a. DIAGNOSIS BEING EVALUATED: Pregnancy (uterine) not delivered — 649.0

9b. OTHER SIGNIFICANT DIAGNOSIS: Lymphoid hyperplasia of appendix — 552.0

11. HOSPITAL SERVICES AND PATIENT: 1

10. THIS chart was not further reviewed because:

12. INVESTIGATION BY PHYSICIAN AS RECORDED (Enter code 1 for males in pelvic and menstrual history)

pertinent history	menstrual history	substantiating physical findings	blood pressure	heart	lungs	pelvic	rectal	reasonable progress notes	x-rays	laboratory	special studies
2	2	2	1	1	1	2	2	1	2	2	1

13. CONSULTATIONS: 3

14. OPERATION: Appendectomy — 661-12

Was operation fully described? 1. Yes 2. No: 1

Was the correct procedure done? 1. Yes 2. No: 1

Was operation justified? 1. Yes 2. No

Was surgery improperly withheld by medical staff? 3. Yes

Was operation refused? 4. Yes: 2

15. DRUGS

anti-biotics	anti-bacterial chemother.	narcotics	sedatives	cardiac regulators	anti-coagulants	whole blood	fluids and electrolytes	oxygen definitive therapy
5	0	1	1	0	0	0	1	0

16. HOSPITALIZATION: 1

17. COMPLICATIONS (If present, write in as well as code:)

1. No complications 2. Justified complications 3. Not justified complications: 1

18. DEATH

19. GENERAL MANAGEMENT OF PATIENT: 4

REMARKS: (Additional remarks are written on the reverse side of the hospital copy.)

Missed diagnosis of pregnancy; Pre-operative diagnosis of Ovarian cyst

FIGURE 2

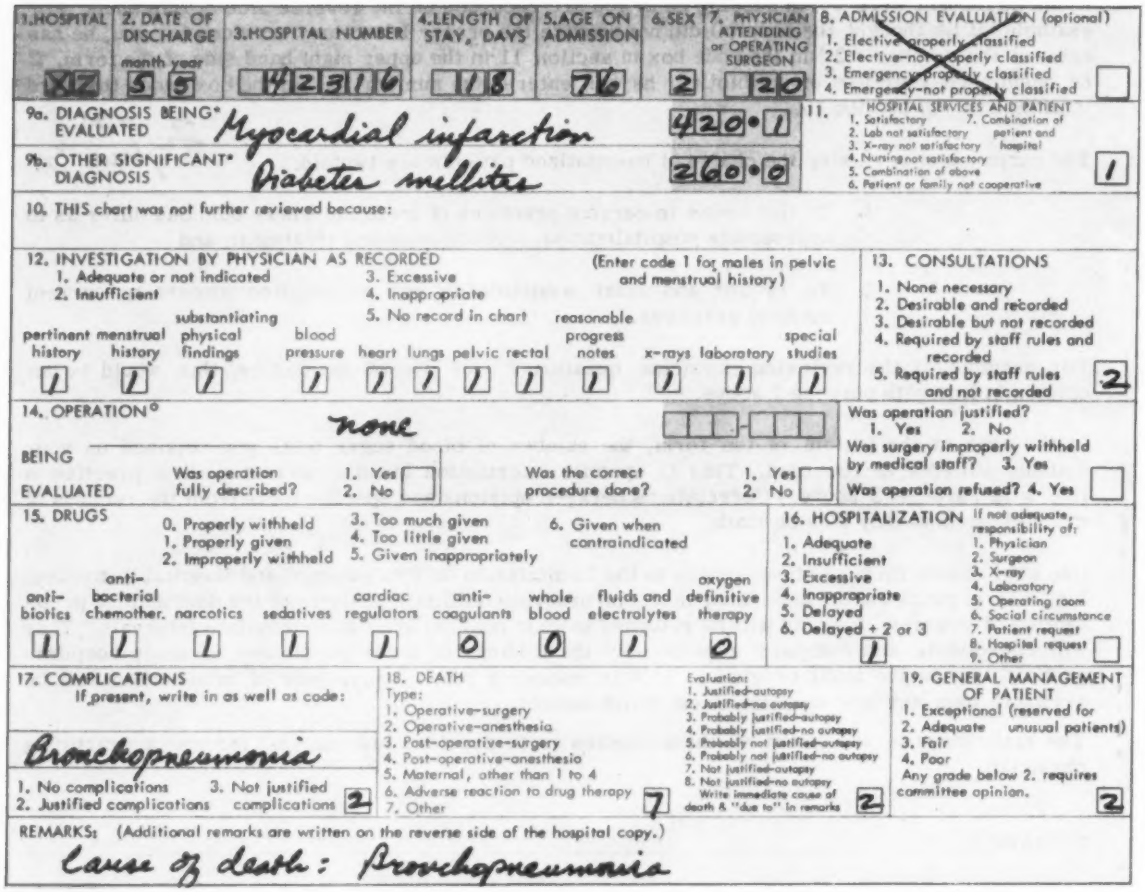
FIGURE 2 records the evaluation of care for a 36 year old female in whom a preoperative diagnosis of ovarian cyst was made. This case was reviewed by the audit committee in its evaluation of primary appendectomies, since the surgical procedure which originally was scheduled as a oophorectomy actually resulted in exploration, with incidental removal of the appendix. The diagnosis of pregnancy was established at surgery. General management of the case was designated as poor because investigation was felt to be insufficient, consultations which would have been desirable were not obtained, and the operation was not considered justified. In addition, antibiotics were given postoperatively, as indicated by the code 5 in Item 15, although there was no valid indication for their use. Narcotics, sedatives, and fluids and electrolytes were properly given.

Arbor, Mich. The tabulations and reports prepared by the commission have the added advantage of displaying the audit data lucidly so that features of hospital practice which are not evident in the consideration of single cases may be clearly seen.

5. Medical auditing is properly directed toward evaluation of clinical practices rather than of clinical practitioners. The College's system has an educational orientation. As such, it becomes a stimulating postgraduate educational program revolving around the physician's own experience in treating patients rather than a chore to be avoided. This positive approach is emphasized and enhanced through the preparation by the commission of inter-hospital comparisons of audit data on a confidential and anonymous basis.

In actual practice the College's medical audit method works this way: All hospitals participating in the audit program audit a basic core of clinical records. This is done in accordance with a schedule developed with the assistance of an advisory audit committee of physicians from the medical staffs of participating hospitals. In 1957, for example, the schedule re-

(*Text Continued on Page 62*)



1. HOSPITAL: XZ
2. DATE OF DISCHARGE (month year): 5 5
3. HOSPITAL NUMBER: 42316
4. LENGTH OF STAY, DAYS: 18
5. AGE ON ADMISSION: 76
6. SEX: 2
7. PHYSICIAN ATTENDING or OPERATING SURGEON: 20
8. ADMISSION EVALUATION (optional)
1. Elective-properly classified
2. Elective-not properly classified
3. Emergency-properly classified
4. Emergency-not properly classified

9a. DIAGNOSIS BEING EVALUATED: Myocardial infarction — 420.1
9b. OTHER SIGNIFICANT DIAGNOSIS: Diabetes mellitus — 260.0

11. HOSPITAL SERVICES AND PATIENT: 1
1. Satisfactory
2. Lab not satisfactory
3. X-ray not satisfactory
4. Nursing not satisfactory
5. Combination of above
6. Patient or family not cooperative
7. Combination of patient and hospital

10. THIS chart was not further reviewed because:

12. INVESTIGATION BY PHYSICIAN AS RECORDED
1. Adequate or not indicated
2. Insufficient
3. Excessive
4. Inappropriate
5. No record in chart
(Enter code 1 for males in pelvic and menstrual history)

pertinent history	menstrual history	substantiating physical findings	blood pressure	heart	lungs	pelvic	rectal	reasonable progress notes	x-rays	laboratory	special studies
1	1	1	1	1	1	1	1	1	1	1	1

13. CONSULTATIONS: 2
1. None necessary
2. Desirable and recorded
3. Desirable but not recorded
4. Required by staff rules and recorded
5. Required by staff rules and not recorded

14. OPERATION: none
BEING EVALUATED
Was operation fully described? 1. Yes 2. No
Was the correct procedure done? 1. Yes 2. No
Was operation justified? 1. Yes 2. No
Was surgery improperly withheld by medical staff? 3. Yes
Was operation refused? 4. Yes

15. DRUGS
0. Properly withheld
1. Properly given
2. Improperly withheld
3. Too much given
4. Too little given
5. Given inappropriately
6. Given when contraindicated

antibiotics	antibacterial chemother.	narcotics	sedatives	cardiac regulators	anticoagulants	whole blood	fluids and electrolytes	oxygen definitive therapy
1	1	1	1	1	0	0	1	0

16. HOSPITALIZATION: 1
1. Adequate
2. Insufficient
3. Excessive
4. Inappropriate
5. Delayed
6. Delayed + 2 or 3
If not adequate, responsibility of:
1. Physician
2. Surgeon
3. X-ray
4. Laboratory
5. Operating room
6. Social circumstance
7. Patient request
8. Hospital request
9. Other

17. COMPLICATIONS
If present, write in as well as code:
Bronchopneumonia
1. No complications
2. Justified complications
3. Not justified complications: 2

18. DEATH
Type:
1. Operative-surgery
2. Operative-anesthesia
3. Post-operative-surgery
4. Post-operative-anesthesia
5. Maternal, other than 1 to 4
6. Adverse reaction to drug therapy
7. Other: 7
Evaluation:
1. Justified-autopsy
2. Justified-no autopsy
3. Probably justified-autopsy
4. Probably justified-no autopsy
5. Probably not justified-autopsy
6. Probably not justified-no autopsy
7. Not justified-autopsy
8. Not justified-no autopsy: 2
Write immediate cause of death & "due to" in remarks

19. GENERAL MANAGEMENT OF PATIENT: 2
1. Exceptional (reserved for unusual patients)
2. Adequate
3. Fair
4. Poor
Any grade below 2. requires committee opinion.

REMARKS: (Additional remarks are written on the reverse side of the hospital copy.)
Cause of death: Bronchopneumonia

FIGURE 3

FIGURE 3, which illustrates the use of the audit check sheet for a medical case, and FIGURE 4, illustrating the Medical Audit Summary, are presented together for purposes of reference. Each horizontal line on the Medical Audit Summary represents information about one patient as recorded on the Medical Audit Check Sheet. For convenient reference the case reviewed in Illustration 3 has been recorded on the summary on the first line. In columns 2 and 3 of the summary are shown the diagnoses found in Items 9a and 9b of the check sheet, myocardial infarction (420.1) and diabetes mellitus (260.0).

Meanings of the diagnostic and operative codes must be sought in the medical records department. Codes for the other information in the summary may be determined by reference to the table of explanation, FIGURE 5. The check sheet may also be used for reference if one bears in mind that findings representing "adequate care" are not printed in the summary; the printing of compliments or criticisms only avoids cluttering the page. Failure of the reviewing physician to complete the check sheet is recorded in the summary by the printing of code 9, as for example in the investigation area for the last case shown in the sample summary (columns 7, 10 and 12).

Columns 4 and 5 record, from Items 6 and 5 of the check sheet, that this was a female, 76 years old. Columns 6 through 17, concerning investigation, reflect Item 12 of the check sheet, and the fact that they are blank in the summary means that the investigation was considered entirely adequate. In column 18, the length of stay of this patient is given as 18 days. Since there is no criticism of the hospitalization of this patient and no surgery was performed, columns 19 through 24 are blank.

Drugs and treatments, coming from Item 15 of the check sheet, escaped criticism in columns 25 through 33, since the 1's indicate drugs properly administered and blanks are drugs properly withheld. The justified complication, broncho-pneumonia, recorded in Item 17 of the check sheet is reflected by the 2 in column 34 of the summary. That this was an infection may be inferred from the summary alone from the use of antibiotics as recorded in column 25. The death was a medical death (7 in column 36), and although no autopsy was obtained it was considered to be justified (2 in column 37). Hospital service was not criticized (column 41) and no evaluation was made of the admission as may be determined from the 9 in column 42. Greater detail, of course, must be sought in the clinical record itself, which may be located through reference to the hospital number as recorded in column 38 (Item 3 of the check sheet).

Page No. 1 Audit Topic CORONARY Year of Audit 55 Hospital X-Z Code

MEDICAL AUDIT SUMMARY

* AMERICAN COLLEGE OF SURGEONS
COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, INC.

			SEX-AGE		INVESTIGATION BY PHYSICIAN												HOSPITALIZATION			OPERATION EVALUATED				DRUGS AND TREATMENTS											DEATHS		HOSPITAL NO. – DATE				
GENERAL MANAGEMENT * (1)	DIAGNOSIS BEING EVALUATED (2)	OTHER SIGNIFICANT DIAGNOSIS (3)	SEX (4)	AGE (5)	HISTORY (6)	MENSTRUAL HISTORY (7)	PHYSICAL (8)	BLOOD PRESSURE (9)	HEART (10)	LUNGS (11)	PELVIC (12)	RECTAL (13)	PROGRESS NOTES (14)	X-RAYS (15)	LABORATORY (16)	SPECIAL STUDIES (17)	LENGTH OF STAY (18)	EVALUATION (19)	RESPONSIBILITY (20)	OPERATION (21)	FULLY DESCRIBED? (22)	CORRECT PROCEDURE? (23)	JUSTIFIED? (24)	ANTIBIOTICS (25)	CHEMO-THERAPEUTICS (26)	NARCOTICS (27)	SEDATIVES (28)	CARDIAC REGULATORS (29)	ANTI-COAGULANTS (30)	WHOLE BLOOD (31)	FLUIDS-ELECTROLYTES (32)	OXYGEN (33)	COMPLICATIONS (34)	CONSULTATIONS (35)	DEATH TYPE (36)	EVALUATION (37)	HOSPITAL NUMBER (38)	MONTH DISCHARGED (39)	YEAR (40)	HOSPITAL SERVICE & PATIENT (41)	ADMISSION EVALUATION (42)
	420.1	260.0	2	76													18							1	1	1	1	1			1		2	2	7	2	42316 1*	5	5		9
	420.1		2	71	2	2	2		2	2				5	5	5	1									1						1	2	3	7	2	136200	6	5		9
4	420.1		2	59	2		2		2	5			2		2		1											5				1		5	7	4	133191	2	5		9
	420.1	241.0	1	44								2	2				7			350-40							1	1						2			2* 506640	6	5		9
	420.1		2	66													23									1	1		1			1					1* 551740	4	5		9
	420.1		1	68													29											1			1			4			1* 199898	4	5		3
1	420.1	782.9	1	40													31							1		1			1		1	1	2	4			1* 122729	5	5	6	3
	420.1		1	37													32									1	1		1								1* 32329	4	5	9	3
	420.1	420.0	2	82													37							1		1	1	1				1		4			1* 196756	1	5		3
	420.1	610.0	1	62		9			9		9						40			764-427							1						2	2			1* 504740	6	5		1
																																					1*				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38 10**	39	40	41	42

FIGURE 4

EXPLANATION OF MEDICAL AUDIT SUMMARY CODING (Form 121-57)

Column No.

1. GENERAL MANAGEMENT OF PATIENT
   1. Exceptional (reserved for unusual patients)
   Blank. Adequate
   3. Fair
   4. Poor
   9. Reviewer's omission
   Any grade below 2 requires committee opinion

2. DIAGNOSIS BEING EVALUATED (Coded by *International* Code)

3. OTHER SIGNIFICANT DIAGNOSIS (Coded by *International* Code)

4. SEX
   1. Male
   2. Female

5. AGE (given in years)

6-17. INVESTIGATION BY PHYSICIAN
   Blank. Adequate or not indicated
   2. Insufficient
   3. Excessive
   4. Inappropriate
   5. No record in chart
   9. Reviewer's omission

18. HOSPITALIZATION LENGTH OF STAY (given in days)

19. HOSPITALIZATION EVALUATION
   Blank. Adequate
   2. Insufficient
   3. Excessive
   4. Inappropriate
   5. Delayed
   6. Delayed + insufficient or excessive
   9. Reviewer's omission

20. HOSPITALIZATION RESPONSIBILITY
   1. Physician
   2. Surgeon
   3. X-ray
   4. Laboratory
   5. Operating room
   6. Social circumstance
   7. Patient request
   8. Hospital request
   9. Other

21. OPERATION (Coded by *Standard* code)

22. OPERATION FULLY DESCRIBED?
   Blank. Yes
   2. No
   9. Reviewer's omission

23. OPERATION CORRECT PROCEDURE?
   Blank. Yes
   2. No
   9. Reviewer's omission

24. OPERATION JUSTIFIED?
   Blank. Yes
   2. No
   3. Surgery improperly withheld by medical staff
   4. Operation was refused
   9. Reviewer's omission

25-33. DRUGS AND TREATMENT CODES
   Blank. Properly withheld
   1. Properly given
   2. Improperly withheld
   3. Too much given
   4. Too little given
   5. Given inappropriately
   6. Given when contraindicated

34. COMPLICATIONS
   Blank. No complications
   2. Justified complications
   3. Complications which were not justified
   9. Reviewer's omission

35. CONSULTATIONS
   Blank. None necessary
   2. Desirable and recorded
   3. Desirable but not recorded
   4. Required by staff rules and recorded
   5. Required by staff rules and not recorded
   9. Reviewer's omission

Column No.

36. DEATH TYPE
   1. Operative-surgery
   2. Operative-anesthesia
   3. Postoperative-surgery
   4. Postoperative-anesthesia
   5. Maternal, other than 1 to 4
   6. Adverse reaction to drug therapy
   7. Other

37. DEATH EVALUATION
   1. Justified-autopsy
   2. Justified-no autopsy
   3. Probably justified-autopsy
   4. Probably justified-no autopsy
   5. Probably not justified-autopsy
   6. Probably not justified-no autopsy
   7. Not justified-autopsy
   8. Not justified-no autopsy
   9. Reviewer's omission

38. HOSPITAL NUMBER

39. MONTH DISCHARGED
   The first nine months are numbers, and the months of October, November and December are O, N, D, respectively

40. YEAR (Last digit shown)

41. HOSPITAL SERVICES AND PATIENT
   Blank. Satisfactory
   2. Lab not satisfactory
   3. X-ray not satisfactory
   4. Nursing not satisfactory
   5. Combination of above
   6. Patient or family not cooperative
   7. Combination of patient and hospital
   9. Reviewer's omission

42. ADMISSION EVALUATION
   Blank. Elective-properly classified
   2. Elective-not properly classified
   3. Emergency-properly classified
   4. Emergency-not properly classified
   9. Reviewer's omission

FIGURE 5

Medical Audit

(*Continued From Page* 59)

quires auditing of all deaths on a current basis, plus the auditing, during the first quarter, of a representative series of primary appendectomies; during the second quarter, a representative series of premature infants; the third quarter, diabetes patients, and in the fourth quarter, complicated deliveries.

In addition, each year will see a more detailed study of two groups of patients, such as coronary occlusions, hysterectomies, bleeding duodenal ulcers, or wound complications, selected because of their clinical importance. In these special evaluations, additional clinical details are recorded by the audit committee and analyzed in a modest type of clinical investigation. The total patients embraced by this schedule will ordinarily represent between 7 and 8 per cent of all of the hospital's discharges and will not exceed 10 per cent. Medical staffs are, of course, given the privilege of auditing additional cases as dictated by local interest or needs.

ESTABLISHES OWN STANDARDS

The medical staff organizes its audit committee in such a manner that appropriate physicians review the various categories of patients. For example, coronary occlusions are reviewed primarily by physicians doing internal medicine, while appendectomies are most often considered by those qualified in surgery. Each medical staff is expected to establish its own standards for the evaluation of care. This policy is essential to the success of the program, for it acknowledges the basic competence of the physician in the hospital, it emphasizes the educational nature of the auditing activity, it permits the auditing to reflect current medical thinking, and it prevents imposition of arbitrary standards from without.

The medical auditing is done in meetings where discussion of interesting or puzzling cases may be carried out at the time the audit check sheets are completed. The completed forms are transmitted by the medical record librarian to the commission's offices in Ann Arbor where punch cards are made and the data are processed by business machines.

Reports of two types are prepared, and returned to the participating hospitals. One of these is a summary (see Fig. 4, page 61) of the hospital's own audit findings prepared by the business machines in such a manner that the medical staff can easily see the scope of its medical auditing activity and the strengths and weaknesses of its medical practice, as judged by its own audit committee. The second type of report is one in which the auditing experiences of the group of participating hospitals (whose identities are concealed from one another) are assembled so that each medical staff may see how its auditing activity and evaluations compare with those of other hospitals in the program.

READER MAY STUDY EVALUATION

With the aid of the explanatory table, the reader may examine the evaluation of the other nine coronary cases which are listed in the Medical Audit Summary. Although review of a category of cases in one hospital would normally concern a greater number of patients, this sample has been limited for illustrative purposes. An interesting pair of cases is shown by the patients on lines 2 and 3, both of whom died within 24 hours of admission: The patient in line 2 is found to have been adequately managed as shown by the blank in column 1, while the patient on line 3 was poorly managed, as shown by the 4 printed in column 1. The investigation by physician in columns 6 through 17 appears to have been insufficient or not recorded in both cases. However, while the treatment of the patient on line 2 was adequate as recorded in columns 25 through 33, the treatment of the patient on line 3 was not, as can be seen from column 29 where the code 5 means the inappropriate use of a cardiac regulator. A further criticism was leveled at this case in column 35 where the 5 signifies that consultation mandatory under the staff regulations was not obtained. These criticisms seem to explain the difference in the general evaluation of the two cases. They also show the emphasis given by the auditor in his over-all evaluation to the attending physician's treatment and his failure to adhere to his own staff regulations.

The patient described on line 7 was handled with exceptional skill as shown by the 1 in the first column. This classification is reserved for unusual patients. In this 40 year old male the second diagnosis was shock (782.9). It is apparent that the seriousness of the case at admission and subsequent good investigation and treatment inclined the evaluating physician to compliment the care given in this instance.

The inter-hospital comparisons, which have not been illustrated here, enable any hospital to compare itself with other participating hospitals in the evaluation of specific facets of care, as for example:

1. Length of stay and adequacy of hospitalization for any age, sex and disease condition.
2. Completeness of the diagnostic investigation of groups of patients similar in diagnosis or treatment.
3. The justification for surgery.
4. The adequacy of significant drug therapy for groups of patients with specific diseases or operations.
5. The types of deaths and their justifications.

NEW METHOD HAS LOGIC

This new method of medical audit puts the evaluation of patient care on a logical, scientific and practicable basis. Specific virtues of the approach are:

1. It is comprehensive in scope; it evaluates the three essential features (hospitalization, investigation and treatment) of the care of any hospital patient, medical, surgical, pediatric or obstetrical.

2. It yields the maximum of useful information with the minimum of effort by the medical profession. A limited number of records of diseases and operations are selected for evaluation by the hospitals' medical audit committees; this relieves the staffs of the senseless dissipation of their time and energy in an impractical, perfunctory and ineffective review of every discharged patient's record.

3. It affords participating hospitals a comparison of the variations in the diagnosis and treatment of identical diseases. Together with the P.A.S. the medical audit provides comparative data not before attainable.

4. It stimulates the reviewing physicians to examine and discuss their criteria of evaluation. Standards for evaluation are not imposed from outside the group but developed within it.

5. It is not punitive in intent, but is designed to facilitate the postgraduate education of physicians by a study of their own cases and by a comparison with the results of other physicians in similar types of diseases and operations.

The Right Price Is Based on Cost in Use

The real price of any article is not first cost alone but what it actually costs in terms of usage, so it is the duty of the purchasing agent to study the usage life of each item in relation to the replacement cost

LAWRENCE BRETT and ALFRED E. SCHLEF

PRICE is simply what you pay for something. There are many prices, but the price the hospital buyer is interested in is the cheapest unit usage cost of the right material at the right place at the right time at the right purchase price. The unit usage cost for any item will vary from hospital to hospital depending upon physical layout, personnel, technics, equipment and other factors. An item that will produce a cheap unit usage cost at one hospital may produce a high unit usage cost at another.

In discussing such items as hypodermic needles and surgeons' gloves with other hospitals in the Cincinnati area, for example, we found wide variations in cost in use. On hypodermic needles, personnel from four hospitals were involved in one study, with each finding a different brand giving the lowest unit usage cost. Each hospital, it turned out, used a different technic in processing hypodermic needles in central supply. Some purchasing agents can do little or nothing about any price other than the purchase price; the purchasing agent then is in the functional position of an order giver, making no important decisions. This is an organizational problem, and the responsibility for the situation rests in the administration.

In a well defined organization the purchasing agent should have clearly defined responsibility and authority. One of the strongest positions is for the purchasing agent to have delegated authority to buy all consumable supplies and capital equipment within the limits of a carefully prepared budget. At our hospital, the capital equipment budget originates in the individual department as a request for capital purchases for the coming year. The department head reviews the needs and requests equipment in three categories: (1) equipment that is essential to the operation of the department; (2) equipment that is helpful to the operation of the department and will reduce labor cost, and (3) items that the department would like to have but are neither absolutely essential, nor will necessarily reduce the cost of operation.

The department heads turn their requests for equipment over to the purchasing agent. The purchasing agent studies all reputable manufacturers of such equipment, using the *Hospital Purchasing File,* various manufacturers' catalogs, and other sources of information. The results are then discussed with the department head and maintenance department to determine what equipment will do the best job for the department and will be least difficult from the maintenance standpoint. The purchasing agent then fills in the estimated cost on the request for equipment and takes all the requests to the administrator. The administrator reviews the requests with each department. If a department head feels that a certain piece of equipment can save a certain number of manhours, the department head is expected to substantiate this by an equal reduc-

The authors are, respectively, superintendent and purchasing agent, Bethesda Hospital, Cincinnati.

This is the second section of an article by Mr. Brett and Mr. Schlef on the nature of hospital purchasing. The first section appeared in the May issue of this magazine.

Hospitals Exempt From Robinson-Patman Act

Some hospital administrators and purchasing agents are not aware that hospitals have been exempted from the Robinson-Patman Act, which forbids price discrimination among purchasers of the same class. The act was passed in 1936 but amended as follows two years later: ". . . nothing in the act . . . known as the Robinson-Patman Anti-discrimination Act shall apply to the purchase of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for profit."

This amendment does not deal with or affect fair trade laws. Fair trade laws and practices vary widely from state to state today, and many court decisions are still pending, making it necessary for purchasers to be familiar with fair trade laws and enforcement practices, in addition to pertinent court actions, in their own states.

tion in his personnel allowance. After the equipment is reviewed by the administrator and department heads and final decisions are made about equipment, the capital equipment budget is prepared and submitted to the financial committee of the board of directors for approval.

Following approval, the capital budget is then given to the purchasing agent, who may purchase the items as specified in designated quarters of the year. The items are purchased, within the limits of the budget, on a competitive bid basis. Expensive items may be reviewed again, prior to purchase, with the maintenance department, the administrator, and the department head.

There are many excellent hospital purchasing agents. They are good purchasing agents because they have ability, education and experience, and because they have the proper organization to use their abilities. There are others who have the potential of being excellent purchasing agents but who are handicapped because of poor organization of their hospitals.

Other hospitals have senior clerks for purchasing agents. Too many hospital administrators and boards of trustees have the false impression that they can get a capable purchasing agent at a senior clerk's wages. They get senior clerks, not purchasing agents. A hospital purchasing agent is a top staff executive. To get such a person, a salary comparable to that paid to a good purchasing agent in business or industry must be paid.

It is the duty of the purchasing agent to obtain the lowest *unit usage cost* for each item used. On an item such as thermometers, there are a number of thermometers, priced at various levels, that have the same accuracy, markings, and other features necessary for accurate patient care. The use life of these thermometers, however, may vary. The purchasing agent should have adequate records to compare the usage life of each item in relation to the replacement cost. An example of this type of information is our central supply department's monthly report, showing an average replacement of 6 dozen thermometers per month during the last year. Two years ago we used a lower priced thermometer. These thermometers lost their pigment markings rapidly, and the replacement for an equal number of thermometers was 12 dozen a month. Thus the lower first cost was false economy.

The relationship between the purchasing agent and department heads must be developed on mutual respect, confidence and cooperation. Regardless of where the purchasing agent is placed on the organization chart, the way he is regarded by the administrator will be reflected in the way he is regarded by the department heads. Just as a competent purchasing agent is an authority in his field, competent department heads are authorities in their fields. When it was decided that new uniforms were needed for the dietary department, for example, the chief dietitian, laundry manager, and purchasing agent reviewed the uniforms shown in various catalogs. Samples were purchased. One gown was picked as being the best by the dietary department, and was to a certain degree acceptable to the laundry manager. However, he was not entirely satisfied with the design, because of the number of pressings necessary. After some discussion, the laundry manager was requested to take the gown to the sewing room and modify it in any way that he felt would reduce labor costs. The laundry manager changed the collar and skirt construction and made other minor changes. The dietary department liked the modified uniform

Purchasing Agent Comes to the Aid of Central Supply

SOME months ago, the central supply supervisor asked for information and help in finding a more efficient method for washing catheters, rectal tubes, and other types of tubing. Among its other equipment, the central supply department has an automatic washer. With the help of the laundry manager, the purchasing agent developed a system using nylon bags similar to those used for washing small items in laundries.

Use of the nylon bags has eliminated several steps from the procedure, as the accompanying outline shows.

The total purchase price of the nylon bags was $12, and it is estimated they will last two and one-half years. By using the new procedure, we are saving approximately 18 man-hours a month in the central supply department. In addition to the actual time saved, a disagreeable job has been eliminated, with resulting improvement in morale.

OLD METHOD

1. Receive catheter tray from floor.
2. Remove items from tray, placing catheters and tubes in pan.
3. Carry pan to wash area.
4. Place catheters and tubes in sink, add soap and water.
5. Wash outsides of catheters.
6. Wash insides of catheters, using syringe to force soap water through tubes.
7. Place catheters in clear water in sink.
8. Rinse insides of catheters, using syringe to force clear water through tubes.
9. Lay catheters out to dry.
10. Place tubes in paper bags or on catheter tray.
11. Autoclave.
12. Return tubes to sterile side of central supply department.

NEW METHOD

1. Receive catheter tray from floor.
2. Remove items from tray, placing catheters and tubes in nylon bag.
3. Carry nylon bag to washing machine.
4. Place bag in machine, add soap, turn on machine.
5. Remove bag from machine.
6. Place tubes in paper bag or on catheter tray.
7. Autoclave.
8. Return tubes to sterile side of central supply department.

Lawrence Brett and Alfred E. Schlef

better than the original. The laundry saved five pressings. The purchase price of the modified uniform was approximately 4 per cent more than the standard uniform. However, the additional purchase price was offset by labor savings in less than one month.

The people who do the actual job—be they nurses, highly skilled maintenance personnel, or the semiskilled dishwasher—are all vitally affected by changes in the products they use. Their advice should be sought, and they should have full knowledge in advance of any change.

PURCHASING POLICY

Purchasing policy should not be set by the purchasing agent. This should be set by the administrator, in cooperation with the purchasing agent. The policy should be broad enough not to hinder the purchasing agent, yet it should not give him license as a czar. If a maximum dollar value inventory is set as the limit of the purchasing agent's authority, it can be done in one of several ways: (1) an absolute dollar value; (2) an absolute dollar value based on the commodity index; (3) a maximum dollar value that can be exceeded for urgent reasons without prior approval but which must be justified eventually; (4) a maximum that is "reasonable." A maximum that is reasonable is the broadest form of responsibility that can be given; this puts the responsibility on the individual, and he must be able to show just cause for the size of the inventory at any particular time.

Governmental agencies are controlled on a formal bid basis, and some hospitals try to follow the same system. There are some items for which this open, formal bid system works excellently. There are other items for which the service rendered by the supplier is of greater importance than the material itself, although there are some services that can be purchased more economically when they are bought separately from supplies or equipment. The alert purchasing agent knows which is which. He also knows that it is foolish to obtain formal bids on small dollar volume purchases.

The importance of service will vary with the size of the hospital, geographic location, and other factors. Some services can be measured in dollars and cents. The surgical dressing studies of technics used in hospitals which are made by the major dressing companies are an example; if these studies are followed, it is possible for some hospitals to save up to $1000 per hundred beds per year.

There are unethical companies, of course, that do not offer real service, but constantly talk about it. The difference between an order giver and a buyer is that the buyer has enough experience and background to use prudence. Purchasing is an art that requires policy, responsibility, authority and prudence.

Specialist Dispute Cost Iowa Hospitals $58,000, Cordes Says, But "We Won the Primary Issue"

Des Moines.—The hospital-specialist controversy cost Iowa hospitals $58,000.

Reporting at the association's 28th annual convention here last month, Donald W. Cordes, administrator of the Iowa Methodist Hospital and chairman of the special committee that handled the controversy for the Iowa Hospital Association, said Iowa hospitals spent that much on litigation, publicity and other costs during the two-year dispute between hospitals and the state pathologists' association and medical society.

All but four of the association's member hospitals paid the assessments levied to meet these costs, Mr. Cordes said. In addition, 15 nonmember hospitals paid assessments to help defray the costs, he added.

The controversy was settled when the Iowa State General Assembly last month passed House File 21, relating to pathology and radiology services in hospitals, legalizing the definitions and arrangements stipulated in an agreement made several months ago between the association and the Iowa State Medical Society.

"We won the primary point at issue—the right to negotiate locally to make mutually satisfactory contracts between hospitals and specialists," Mr. Cordes reported.

Leon A. Bondi, administrator of St. Luke's Hospital, Davenport, was elected president of the association during the convention. He succeeded F. A. Hanson, Iowa Lutheran Hospital, Des Moines. James A. Anderson, administrator, Lutheran Hospital, Fort Dodge, was named president-elect.

Under the new law, hospitals offering pathology and radiology services must have physicians in charge of these departments, Ray Johnson Jr., attorney for the association, said in a session devoted to interpretation of the law and suggestions for its implementation.

"In the event that any hospitals do not have doctors in charge of these departments, this must now be done," Mr. Johnson explained. "The doctor in charge need not be a specialist in the field of radiology or pathology, and it is to be hoped that in the smaller hospitals these services may be obtained without compensation."

Other requirements called for in the law were explained by Mr. Johnson as follows:

1. Hospital patients or their legal representatives must sign admission agreements containing a paragraph set forth in the law, stipulating that pathology and radiology services are medical services and that charges for such services may be collected by the hospital on behalf of physicians, by agreement.

2. Names of doctors in charge of these services must be placed on hospital bills, and the bills must contain a statement indicating that pathology and radiology charges are medical services "rendered by or under the direction of the doctor listed above and collected by the hospital on behalf of the doctor, from which charges an agreed sum will be retained by the hospital in accordance with an existing agreement."

3. The act stipulates that the doctor and hospital shall "mutually agree upon the employment of technicians" and that no technicians can be dismissed except on mutual consent of doctor and hospital.

4. All fees charged for pathology and radiology services are to be mutually arranged by the hospital and doctor. "In the event disputes shall arise between the parties, the matter shall be submitted to the joint conference committee for final determination," the law stipulates.

5. Hospitals should make certain that doctors in charge of these departments are carrying adequate malpractice insurance to cover operation of the department. "In the case of a doctor performing these services gratuitously," Mr. Johnson suggested, "it would seem perfectly appropriate that the hospital arrange for and pay for the premiums on malpractice insurance covering this

(*Continued on Page* 182)

Flexibility Made Remodeling Painless

A "chess game" operation made it possible for this hospital to carry out an extensive remodeling program around the patients without interruption of service

GILBERT O. LINDGREN

ONE interesting aspect of the rehabilitation and remodeling program at Trinity Lutheran Hospital, Kansas City, Mo., has been the planned sequence of development. Few beds were lost to service during the period of construction, and no service to patients was interrupted, yet every step of progress led directly toward the ultimate plan. This is not to say that there were no inconveniences. The inconveniences were minimized and made bearable by both employes and patients. People are wonderful when they understand the problems and the objectives.

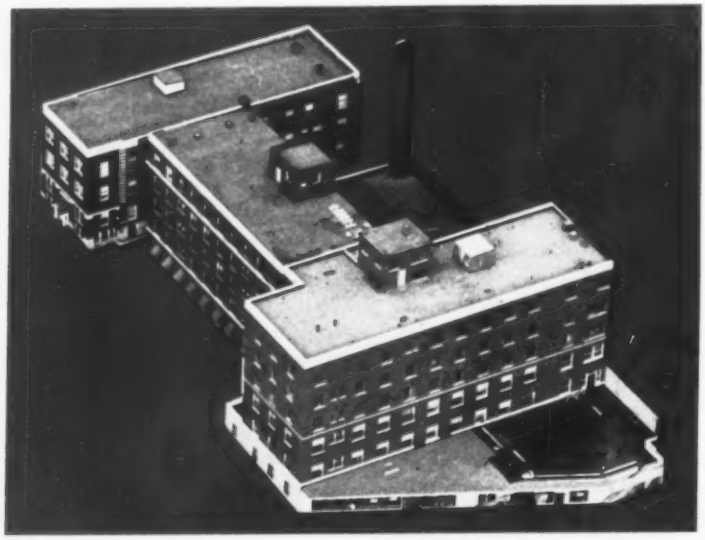
The fact that the whole hospital had to be reoriented with respect to the main entrance from the north to the south, that service areas and patient areas had to be expanded, and in some instances moved, made possible a chess game operation, with moves and alternate moves determined in advance. The three-story south wing with some 40 patient beds had to be gutted completely in order to develop the new floor plan. The old patient rooms were merely boxes with no facilities whatever. The final plan called for toilet facilities, a lavatory, modern nurse-to-patient call system, piped oxygen, a built-in locker and dresser, and ducts for air conditioning. This meant that extensive new plumbing, sheet metal, and electrical work had to be carried up through the existing three patient floors to the three new floors above, and the entire floor arrangement had to be altered to provide utility rooms, showers, nursing stations, and so forth.

Alternate toilet facilities, utility rooms, and nursing stations were provided in the newly built area between the north and south wings so that any floor could be kept in service even when construction was in progress.

We usually took two rooms out of service at a time while the electrical and plumbing services were brought through the existing concrete floors to the floors above. Motor driven rotary drills eliminated much noise. We doubled some private rooms in other parts of the hospital in order to keep up our bed complement. With excellent cooperation and liaison between the construction foreman and the nursing services, we moved the cutting and drilling operations from room to room through three entire patient floors with some inconvenience, of course, but no interruption of patient care. The housekeeping staff followed up each day to keep debris and dust cleaned up.

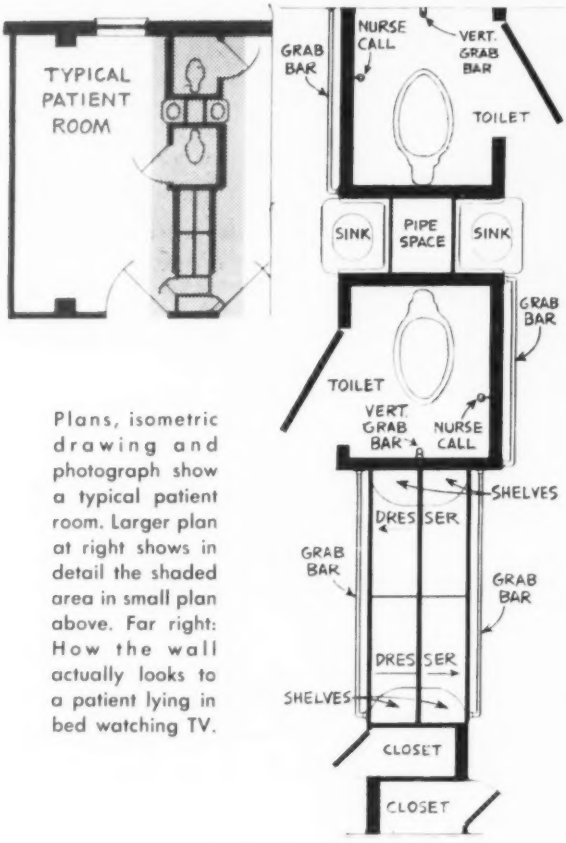
With these cutting operations finished on the first three floors, we then completely finished the floors from the top down. When ready for occupancy, we moved the patients up floor by floor as they were completed. We then continued the alterations on the first three floors from top to bottom ending with the lobby and front entrance.

Mr. Lindgren is administrator, Trinity Lutheran Hospital, Kansas City, Mo.

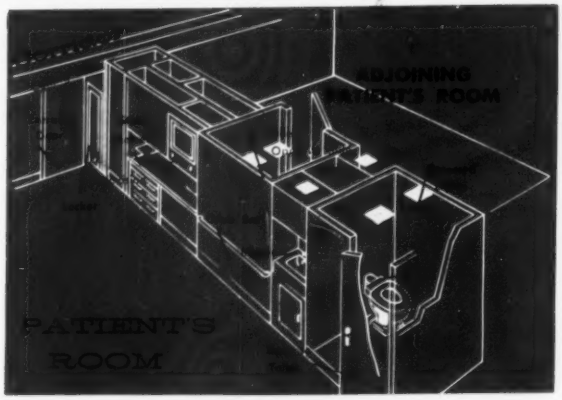


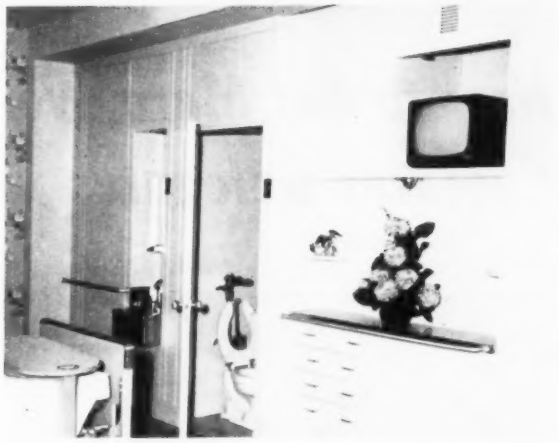
South elevation of Trinity Lutheran Hospital at the completion of the remodeling when the entrance had been moved from the north wing to the south. Ambulance entrance is at right of the entrance to lobby.

PREFABRICATED SERVICE WALL ELIMINATES MUCH MOVABLE FURNITURE



Plans, isometric drawing and photograph show a typical patient room. Larger plan at right shows in detail the shaded area in small plan above. Far right: How the wall actually looks to a patient lying in bed watching TV.





The prefabricated wall illustrated above was designed by the administrator to get more space about the patient's bed. This design added 25 to 35 more square feet of usable space to each room. Fixed service facilities built into the walls include: toilet and lavatory for each two patients; four-drawer dresser with ledge for flowers and other items; recessed television niche; centralized radio facilities with pillow speaker that can also be used for audio portion of TV; nurse-patient call system; reading lights; piped oxygen, and air conditioning ducts. The only movable furniture now needed in patients' rooms is two beds, two bedside tables, two overbed tables, and two chairs.

IN REDESIGNING THE KITCHEN, THEY FIGURED IN INCHES TO SAVE FEET

AS IS true in any remodeling program our big problem at Trinity Lutheran from the start had been the most efficient utilization of existing space. Since we often had to do more work in the same area, the solution to many of our problems lay in the study of work and traffic flow to eliminate waste motion, cross traffic, and waste of space. We found, for instance, that the space for the operator of the dishwasher could be cut from 30 by 48 inches to 30 by 30 inches and not only increase his efficiency, but provide a work area directly behind him. By bringing his dish table to the side of the loading end rather than directly in front of it, as we originally planned, we arranged the space so the operator would not have to move from his working position to load the dishwasher.

Much of our figuring was done in square inches rather than square feet. We were able to reduce the already small baker's area by one-half. We put the surface cooking tops in the center of the food preparation area, so that we could prepare the general diets on one side and the special diets on the other, utilizing the same equipment. We more than doubled our working counter area by utilizing all outside walls and, in addition, acquired more aisle space between stoves and counters to facilitate free movement of carts. By eliminating present hall traffic through our dietary department, we gained still more space.

The same technics were used in planning surgery. By cutting away 6 inches under a hose cabinet near the elevator, we got temporary storage space for a surgery cart, without interfering with the elevator opening. One of the surgery rooms has been equipped with an overhead tube crane for x-ray work; we saved space by using the same control unit installed for the GU unit in the room adjacent to it. Pathology and radiology are on the same floor as surgery with an intercom connection between them. This arrangement is convenient and efficient.

TRI-STATE: A familiar scene to veterans of the Tri-State Hospital Assembly is the jam around the registration desk on the opening day. Some 8000 registrants—administrators, department heads and exhibitors—set another attendance record.

How to Get More Work Out of Fewer People Concerns Delegates at Regional Meetings

Rising costs and charges, falling nurse enrollments, and the A.H.A. building program keep corridors buzzing during Tri-State, Southeastern, Western and Mid-West Conventions

THE everlasting task of the administrator—how to get more work out of fewer people—was examined from every possible angle by speakers and audiences at the regional hospital conventions this spring. When the conventions were over few problems had been solved, perhaps, but speakers and audiences had exchanged a great deal of information, and a little wisdom, and everybody felt better.

As it always does, the information that was exchanged concerned hospital costs and charges, which are going up, and enrollment in nursing schools, which is going down; automation, which is entering the hospital, and charity, which one convention speaker said is leaving; hospital liability, which is increasing, and hospital collections, which are dwindling.

At this year's conventions, there was less concern about accreditation and medical staff problems than has been apparent in other years, and more concern for disaster planning; there was less talk about recruiting personnel and more about using people effectively; less concern about public relations and more about human beings.

Peculiar to this particular convention year, too, was another subject of lively conversation, on and off convention floors: the building and financing plans of the American Hospital Association. The size of the A.H.A. building, and the amount of the A.H.A. clout, were debated hotly in hotel rooms and corridors from Atlanta to Los Angeles. With few exceptions, however, the debates cooled off when A.H.A.'s critics and defenders met face to face in scheduled convention sessions. At most of these sessions, the critics were outnumbered, and outtalked, by the defenders.

Taking time out from his assigned task of relating and explaining the unhappy recent history of the headquarters building project, one of the defenders, Past A.H.A. President Ray E. Brown of Chicago, contributed a large share of the season's small store of real wisdom when he told administrators attending a personnel session at the Southeastern Hospital Conference in Atlanta to stop trying to be mothers and fathers and ministers, as well as employers, of hospital workers.

"Why should we try to meet all the needs and interests of our workers?" Mr. Brown asked. "Churches, taverns, ball parks, television and the family are supposed to meet many of their needs. The hospital organization has only a few abilities and resources; if we satisfy just the needs that we can satisfy, we will increase the productivity of our people."

As needs that can be met by employers, Mr. Brown listed:

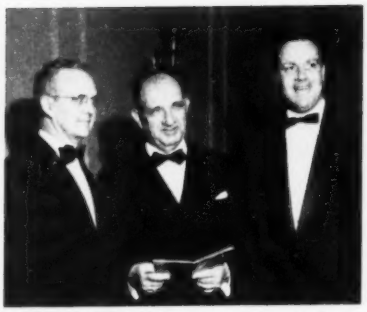
1. **The need for direction.** For the worker, direction begins with training, Mr. Brown said. "Better have workers misdirected than undirected," he added.

2. **The need to be evaluated or judged.** The worst thing that can happen is for a worker to have the feeling that nobody cares whether he does his job well or poorly, Mr. Brown pointed out. "Too many hospital administrators are afraid to criticize," he declared.

3. **The need to succeed.** If the worker fails to get recognition for success on the job, he will seek success in other ways—sometimes by becoming a critic of the hospital organization.

4. **The need to participate.** "Workers must be told about the goals and plans of the organization, so they know

WESTERN: Officers of the Association of Western Hospitals, left to right: Alfred E. Maffley, outgoing president; Guy M. Hanner, incoming president, and Melvin C. Scheflin, executive secretary. (For meeting report, see p. 158.)



MID-WEST: Left to right: Hubert Hughes, Denver, retiring president; Bryce L. Twitty, new president, and James G. Carr Jr., president-elect of the Mid-West Hospital Association. (For report of meeting, see page 160.)

SOUTHEASTERN: At the Southeastern meeting (p. 70) Robert C. Ivy was named president-elect. With him, l. to r., are President Pat N. Groner, Vice President Oscar Hillard, and Charles W. Flynn, executive secretary.

what's going on." Mr. Brown said. However, he warned against the kind of leadership that lets employes make decisions which are management's responsibility.

Echoing this call for restraint in the application of democratic methods in administrative leadership was another speaker at another convention. Addressing the annual luncheon sponsored by the American College of Hospital Administrators at the Tri-State Hospital Assembly in Chicago, Harold G. Shane, professor of education at Northwestern University, identified several "malpractices" in democratic administration. These are:

1. **Enfeeblement of leadership** by concern for what is popular and will work as opposed to what is right.

2. **Too much talk at the expense of action.** "Some loss in group processes may be worth while if important things are going to happen fast enough," Dr. Shane said.

3. **Too many heads.** "It isn't necessary to have everybody in on everything. The right of referendum and recall must be preserved, but that's all."

4. **The authority-responsibility dilemma.** "Only the head man is accountable," Dr. Shane reminded the group. "Authority can be shared, but not responsibility."

5. **The "bruising majority"** that may damage minority interests. Strong leadership must guide decisions in terms of the general welfare, Dr. Shane warned.

6. **Willful minorities.** Minority interests may also harm the enterprise unless properly led, he added.

7. **Poor communication.** As means of communication have improved, intelligibility has declined, Dr. Shane said. Especially, administrators should be on guard against the kind of misunderstanding that results in apparent agreement when there is actual disagreement, he pointed out.

8. **Interruption and harassment.** In using group processes, administrators must be on their guard against excesses that prevent necessary work from being done.

9. **Turnover.** "In building a team, you can never win," Dr. Shane said. "Turnover erodes the best teams."

Cooperative relationships develop slowly and are unique, Dr. Shane concluded. "One process works in one institution, and another process in another institution," he told the group. "The administrator must be the judge of where to begin and how far to go. He mustn't expect too much too soon—there is always free cheese in a mouse trap."

Plainly, at the 1957 conventions the pendulum was swinging back from the playschool approach to administration that was recommended in convention speeches a few years ago, at the high water mark in the hospital field of group dynamics or "groupness," as Dr. Shane called it at one point, lapsing into the *patois* of the methodology he was warning his audience to apply cautiously, in homeopathic dosages. #

Tri-State Hospital Delegates Urged to Base Rate Structure on Service Costs

Chicago.—Reverting to its original, three-day span when it developed that nearly everybody tired in the stretch at the longer distance, the Tri-State Hospital Assembly this year maintained its record as the leader among regional hospital conventions in attendance and diversification, with some 8000 registrants deployed among 40 separate groups, taking the treatment from 261 listed speakers.

Inevitably in the Tri-State numbers game, there are occasions when the speakers outnumber the audience, and there are occasions, too, when the audience takes over and does most of the talking.

At the two general assemblies this year, however—on rates and legal problems—the audiences were large and attentive, and the speakers informative. At the session on rates, hospital economists emphasized the need for realistic rate structures based on service costs. Reporting results of an extensive study of hospital charges in Michigan, William C. McNary of Detroit, executive vice president of Michigan Hospital Service, said the costs of room and board and general administration are not met by room charges, but income from ancillary services exceeds the cost of these services. "The load on ancillary service charges is not justified," Mr. McNary declared. "Sick patients are being penalized, and those who are not so sick are subsidized by this system of charges."

The system of loaded charges also puts the service benefit program of Blue Cross at a disadvantage compared to insurance indemnity plans, Mr. McNary added.

"Placing the load where it belongs

TRI-STATE: Far left: Signa Thomas, Canton, Ill., and Rose Marie Wilmot and Alice Pohl of Beardstown, Ill., watch demonstration of sling for hoisting patients. Left: Mary Ellen Anderson, chairman of the central supply section, discusses improved work methods for supervisors with Russell W. McBride (left) and T. N. Silzer, speakers at the meeing.

will add to hospital income, and patients will like it better," he concluded.

The desirability of higher rates for room and board and lower rates for ancillary services was also emphasized by C. Rufus Rorem, executive director of the Hospital Council of Philadelphia.

"Ancillary services are the aspects of hospital care most essential to good diagnosis and treatment, yet least subject to control by the patient himself," Mr. Rorem said. "Higher charges for room service tend to encourage short stays. Lower charges for ancillary services tend to encourage good diagnosis and treatment."

At the same time, detailed cost information about each ancillary service is not significant for establishment of charges, Mr. Rorem added. "From the patient's point of view, hospital service is a single experience," he said. "Few of the services are performed because he wants them. He is more interested in the size than the composition of the hospital bill. It's not the cost, it's the uncertainty which makes hospital bills so hard to pay and so difficult to collect. A pricing policy that will enable the patient to predict the amount of his bill will assist him in the payment of that bill."

At the assembly on legal aspects of hospital administration, Dr. Charles U. Letourneau of Chicago, associate professor and director, Program in Hospital Administration, Northwestern University; consultant in hospital administration; and editorial director, *Hospital Management*, related an episode in which a hospital patient was attacked and slashed by another patient armed with a knife. In the ensuing scramble, the knife-wielding patient was also injured.

"The hospital was sued by both the slicer and the slicee," Dr. Letourneau reported, "and they both collected damages."

In another talk at the legal session, Albert Stump of Indianapolis, attorney for the Indiana Hospital Association and Indiana Medical Association, said the law governing legal responsibilities of hospitals and medical staff members changes with the progress of medical care in hospitals.

"The staff member has a responsibility to his patient in selecting a hospital and seeing that proper equipment and personnel are available for the service needed," Mr. Stump explained. "He is responsible for making his orders and directions clear. While he should conform to the rules of the hospital, ordinarily the breach of them subjects him only to the disciplinary measures of the hospital, unless the patient is injured thereby."

Principles of the law are relatively unchanging, Mr. Stump added, but progress in medicine may rapidly change the facts to which general principles apply. "Thus the results, as far

(*Continued on Page* 180)

Hospital Costs and Rates Will Continue to Rise, Dr. Crosby Tells Southeasterners

ATLANTA, GA.—Hospital costs and rates were the principal subject of discussion, in and out of scheduled meetings, at the 20th annual Southeastern Hospital Conference here last month. With more than 1700 attending, the conference brought together hospital executives from Georgia, Florida, Alabama, Mississippi, Louisiana and Tennessee.

Meeting with administrators were separate conferences of nurse anesthetists, dietitians, pharmacists, medical record librarians, and auxiliaries.

Speaking at the opening session of the convention, Dr. Edwin L. Crosby of Chicago, executive director of the American Hospital Association, said that hospital costs and rates would continue to rise in the future, along with the cost of living and price rises in the general economy.

In a detailed discussion of rates at another meeting, Ray E. Brown, past president of A.H.A., said the first principle in establishing hospital rates is that they must yield an income adequate to meet the hospital's total needs. "Solvency is mandatory," he said. "It is the first test of management."

In addition, Mr. Brown said, the hospital rate structure must also take the following factors into consideration:

1. Rates should reflect each individual's use of the hospital to the closest extent possible. This does not mean that each service must be priced precisely according to its cost, Mr. Brown explained. Rather, the goal should be to have each user of hospital services pay in proportion to the services actually used—including the important "standby" service, he added.

2. Rates should result in accounts that are collectible. Thus some rates that are below cost may actually be justifiable, Mr. Brown said. "Unfortunately, this means that the sick who can pay must carry a part of the load for those who cannot pay," he acknowledged. "But this is inevitable, to some extent," he said.

3. The rate structure should be as acceptable and as understandable as possible to patients. "Rates must have equity and make sense to those who pay," Mr. Brown explained. "This is not always logical, because the patient is more willing to pay for what he feels and sees than for hidden services, such as laboratory service."

4. The rate structure should inhibit necessary use of hospital facilities as little as possible. The doctor is prone to do without a service where cost to

(*Continued on Page* 184)

Doctors Will Give—But Don't Crowd Them!

This survey of fund raising counsel, hospital administrators, trustees and doctors shows that medical staffs contribute 20 per cent of the total in most hospital campaigns, but the doctors do require special handling, and pressure is likely to backfire

IN THE last ten years, the nation's doctors have contributed a whopping $500 million toward expanding and improving our community hospitals.

That's an estimate based on a recent survey of doctors' contributions to hospital fund raising campaigns. The survey was conducted chiefly among members of the American Association of Fund Raising Counsel and other professional fund raisers—the men who operate behind the scenes in most campaigns, setting quotas, holding meetings, arranging publicity and keeping the volunteer organization working. It also included reports from hospital administrators and trustees, and from a number of doctors, some of whom had given generously to their hospitals, and some who were counted among the holdouts when their hospitals passed the hat.

The survey showed that doctors contribute nearly 20 per cent of the total amount raised in most hospital campaigns. Of course, the performance varies widely from community to community. In some campaigns the doctors have contributed as little as 3 or 4 per cent of the total; in others, doctors have taken a leading part. In a campaign to provide funds for expansion and modernization of a small hospital in one Midwestern city, for example, doctors on the staff contributed 70 per cent of all the money that was raised. But in a New Jersey community the doctors staged a sitdown strike against hospital donations, and the campaign was a flop as a result. The average amount contributed by doctors in all the campaigns reported was just under 20 per cent of the total.

Is that good or bad? How much should doctors give when their hospital is conducting a building fund drive?

Professional fund raisers answer this question out of the book, according to the particular quota systems they use, but individual physicians may come up with entirely different answers, according to the dictates of their experience and their consciences. In a recent survey of the political, religious and community activities of physicians, for example, a number of respondent physicians named the community hospital as their favorite charity.

GIFTS VARY WIDELY

As it would in any group, this meant different things to different men. A 47 year old obstetrician in Ohio gave his hospital $10,000. An 80 year old GP in Illinois gave $16,000 in 1955 and volunteered that he had promised "much more" this year. A 49 year old practitioner in another Midwestern state obviously considered himself a major philanthropist because he gave $1000 in the hospital building drive. The smallest amount reported by a doctor who listed the hospital as his favorite charity was $500.

How do these gifts compare with those of businessmen having comparable incomes?

Some fund raisers and hospital trustees felt that doctors have been generous in their response to appeals for support of their hospitals. Many added that the doctors set the pace for the entire campaign, contributing as much in leadership and enthusiasm as in money to the success of hospital drives.

Others took a dimmer view of the doctors' generosity.

A few—possibly soured by experiences in campaigns where doctors withheld their support—insisted that the doctor is a cheapskate, giving only when he has to, and as little as possible.

This is a matter of opinion, of course, since no exact figures on the subject would be available except through examination of income tax returns. The campaign directors for the most part are inclined to the view that the doctor's charitable impulse, at least as it is expressed in cash gifts to hospital fund raising campaigns, lags behind that of his businessman neighbor. Acknowledging that the doctor frequently makes generous gifts of his time and services for charitable purposes, many fund raisers, hospital administrators and trustees—and some doctors themselves—nevertheless attribute the doctors' generous percentage of the total contributions to hospital campaigns largely to their comparative prosperity as members of the community, their close relationship to the hospital, and the benefits they derive from it.

Furthermore, it is generally felt among fund raising counsel that doctors as a group are more difficult to work with than others. "Doctors as a group are more sensitive about money than others are," said one of them. "A study into the psychological reasons for this would be interesting. Perhaps they fear sizable contributions by them would be a confession of ill-gotten

"One doctor's efforts to help went unrewarded when, after the hospital was built, he was excluded from staff privileges"

wealth, or substantiation of the lay feeling that most doctors make more money than they will admit. The same feelings may beset the businessman, too, but they seem to be more prevalent among doctors."

Some doctors, moreover, make flashy pledges but don't pay up. Campaign directors keep a fairly accurate check on the payment of pledges and usually advise clients to plan for a shrinkage of 5 to 10 per cent, though it may be as low as 1 per cent in some cases. Some of this shrinkage is caused by the failure of staff members to meet pledges, they say. Several episodes are in the record of doctors who owned expensive automobiles and beautiful homes, but who paid little or nothing on their hospital pledges.

TOOK PART IN STUNT

Sometimes, on the other hand, the support of doctors in a hospital drive is carried to fantastic lengths. When the hospital in Ballard, Wash., a suburb of Seattle, launched its drive for funds three years ago, doctors on the staff took part in a bizarre stunt, calling their patients at midnight and asking them to rush to the hospital to meet an emergency. As the bewildered patients, some of them still in pajamas, gathered sleepily in the hospital auditorium, the doctors asked them for contributions to "help the sick hospital situation."

Some of the patients, and some doctors, objected that the stunt was undignified—but it raised money.

On another occasion, a doctor's efforts to help in the hospital's fund raising drive went unrewarded when, after the hospital was built, he was excluded from staff privileges. "At the very first meeting we were strongly assured that this hospital was to be available to every family doctor," he wrote in a scathing letter to the administrator. "Because of that understanding, family physicians and their wives, old and young, trudged the sidewalks, rang doorbells, and suffered the slights, the insults, and the heartbreak of those who solicit alms. Weekly meetings were regularly attended, at the expense of income-producing time, by these faithful and hopeful workers.

"Not one specialist was seen nor heard of during this hectic money-raising campaign. But, even as the first spadeful of earth was turned, those who labored and sacrificed to bring the dream to full fruition were discarded as casually, and for the same reason, as a used surgical dressing. They had served their purpose."

Hospital authorities in this case acknowledged that some general practitioners assisted in the campaign and were later denied privileges, but pointed out that the assistance was voluntary and that the medical organization was established by the doctors themselves, with appointments and privileges granted on the basis of merit.

Fortunately, most campaigns have a happier conclusion. In some cases, doctors and campaign directors, working together, become fast friends. Writing to the campaign director at the conclusion of a successful hospital drive, the chief of staff of a hospital in North Dakota described the feeling that can emerge from a common effort toward a useful community purpose. "Never before have I realized that this community needed just such a drive, needed the earnest inspiration to greater and finer achievement," the doctor wrote. "We have completed the drive—way over the top! Moreover, we have benefited immeasurably, far beyond the half million dollars pledged. A fortune of uncounted wealth in new friendships, better understanding of others, and a finer tolerance among the people of all races and creeds is our real treasure."

An old hand, the campaign director to whom that letter was written shrugged it off as routine. "Doctors become so convinced of their infallibility on most all subjects that they must be approached with caution, handled with kid gloves, and, for the most part, left undisturbed in their preconceived ideas," he said. "The success of fund raising campaigns for hospitals almost invariably is in direct proportion to the interest, leadership and contributions of staff members."

Of course, there are wide variations in attitude and performance within medical staffs themselves. A common experience reported by fund raisers was that most members of the medical staff would join enthusiastically in the fund raising effort, but one or two might drag their heels, sometimes damaging the entire program.

In hospital campaigns, an objection by doctors is viewed as a calamity. The reason is simple: If the doctor won't support the hospital campaign, who on earth will? People in the community feel no one knows the hospital's needs better than the doctors do. Because of this feeling, doctors must lead the way in any hospital campaign.

HARD ON YOUNGER MEN

Some doctors say this results in undue pressure on doctors to make substantial donations. "It's all very well for the chiefs to sit in a meeting and decide that I should give $1000 a year for three years in our building fund drive," a young internist said. "It doesn't sound like much to them, I know. But I just opened my own office last year, after years of working for one of the older men on the staff as an assistant, at a small salary. I have my family to raise, and I'm still paying off debts. I'll give the $3000 all right—what else can I do?—but it's going to hurt!"

Here and there, other evidence appeared indicating that doctors felt they had been pressured into making contributions, so they gave generously for fear of being discriminated against. "If a physician wants to contribute to a hospital he is at liberty to do so, and in fact is often required to do it as a matter of conscience," said a Massachusetts doctor. "It is important, however, that he makes his contribution as just another member of the community. There is an important distinction between a contribution made as a civic obligation and one made as the result

"There are several systems of rating doctors according to giving ability, and establishing specific quotas for their contributions"

of pressure upon a special group. After all, many special groups besides doctors derive benefit from the hospital."

Hospital administrators and trustees responded to the "just another member of the community" view with a loud horse-laugh. "Why shouldn't the doctors give? Look what they get out of it!" said one trustee.

Unquestionably, this attitude has resulted in high pressure tactics in some campaigns, as in the case of a doctor who reported his hospital took a "tax assessing attitude" and demanded $1000 donations from staff members.

In one Chicago hospital, the medical staff itself applied the pressure to laggard members, drafting and approving an amendment to the staff by-laws requiring members of the senior and associate staffs to contribute $3500 each to the hospital's expansion fund. "Failure to comply with this rule shall constitute automatic transfer to the courtesy staff," the amended by-laws stated. Members of the courtesy staff, another by-law stipulated, were permitted to admit patients to the hospital "only when the census of the medical and surgical departments is declared by the administrator to be below 70 per cent."

MANDATORY GIFTS CONDEMNED

Although the pressure in this case was applied by the staff itself, and not by the hospital, and, in fact, the hospital board had misgivings about the amended staff by-laws and withheld approval for several months, the maneuver caused such an uproar among physicians that the Chicago Medical Society was moved to pass a resolution condemning mandatory contributions to hospital campaigns.

While there are some widely scattered reports of pressure for staff donations applied by hospitals, it seems likely that in most instances, as in this one, where pressure is applied it comes from within the staff itself. Experienced fund raisers who approach the hospital situation as professionals without any interest in the medical staff except as a source of money and leadership all agree that *pressure tactics usually don't work*. For every doctor who is pressured into giving, or giving more than he really wants to, there are 50 who will be disaffected by high pressure methods and won't give at all.

Statements like this were made by men who have lived through hundreds of hospital campaigns: "We avoid pressure as we would the plague. It is something we absolutely will not permit, either through the volunteer organization or through our own professional staff. There is no surer way to wreck your chances of conducting a successful campaign."

Another reason for variations in contributions by the medical staff is the difference in campaign technics. In detail, there are probably as many different methods of organizing and soliciting the medical staff as there are hospitals. In general, however, one rule prevails in successful drives: The staff organizes itself, sets its own quotas, and conducts its own solicitations, with only behind-the-scenes guidance from professional fund raising counsel and no interference at all by hospital trustees.

"The secret of success is in the evaluation system used by the staff members themselves," reported a fund raiser who has been able consistently to get staff contributions ranging upward from 25 per cent of the total. "It is their show and must remain so. We have always insisted on a number of meetings with key members of the medical staff at the outset of campaign planning, and at least one or two meetings with the entire medical staff. To be perfectly frank, we think the answer is in the professional fund raiser's handling of the medical staff. Boards of trustees of hospitals and other volunteer campaign personnel are prone to exert pressure directly or indirectly, if the professional fund raiser does not control the situation. We insist on handling the medical staff ourselves."

At a recent staff conference of a large fund raising firm, one member gave a lecture on the proper method of handling doctors during a campaign. Here are some of the points he emphasized:

"1. Don't pressure the doctors in a hospital campaign. The hospital administrator should not be present at meetings with the doctors.

"2. Meet with the chief of staff, having with you an A-to-Z list of the doctors on the staff. Try at this time to get some idea as to their giving ability.

"3. Length of service or seniority are not the most important items to consider. Ability to give should be the deciding factor.

"4. Only the chief of staff and the campaign director know the results of the ratings. Thus there is no outside pressure exerted on staff members."

SYSTEMS FOR RATING DOCTORS

There are several systems of rating doctors according to giving ability and establishing specific quotas for their campaign contributions. One hospital staff, for example, used a point-rating system that worked like this:

Every doctor on the staff was rated on a unit scale, with the chief of staff, or the most active surgeon, having a rating of 10 points, and the newest or least active members a rating of one point. When all the members were rated, the total number of units was divided into the doctors' campaign goal, which was 20 per cent of the total campaign goal, and each doctor's share was then established according to the number of units he had been assigned.

Of course, the joker in this system is that the point-rating was done by the chief of staff, in conference with the campaign director, and some of the doctors felt they had been rated too high.

"Some of them always do," the campaign director said sadly. The hospital's dilemma was described by one man in these terms:

"The older members of the profession feel that the younger members should give more substantially, because they will be using the facilities to be

(*Continued on Page* 150)

Patients' Relatives Can Worry in Comfort

The attractive surgical lounge at Henry Ford Hospital provides a soothing atmosphere for anxious relatives and makes them feel that someone is interested in them

DAVID L. EVERHART and ROBIN C. BUERKI, M.D.

ONE of the problems that confronts the administrator of today's hospital is the danger that with bigness and specialization, too frequently comes impersonalized treatment of the patient and his family. It is the little things that count in a patient's reaction to the hospital environment. It is the housekeeper's smile or the cashier's abruptness that may turn an otherwise uneventful hospitalization into one in which the patient is either completely satisfied and grateful for the care he has received or critical of everything.

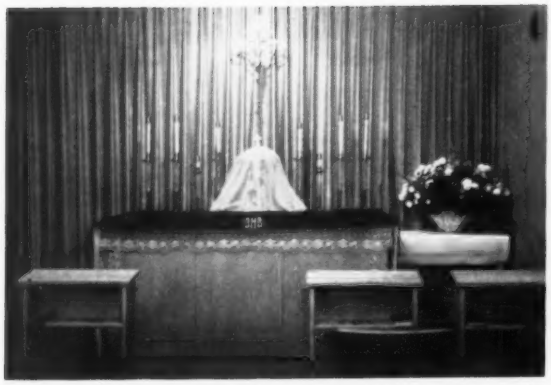
This also applies to the reception and treatment accorded the patient's family and friends. The small niceties —the little extras over and above expected service—are what can make the difference in people's attitudes.

Of the many people who visit a hospital in the course of a day, one group that is likely to be lost or forgotten is the family of the patient who is undergoing surgery. These people, who are usually caught up in the emotional impact of their own problems, are often given the feeling that they are in the way. The hard-pressed nurse can do little more than reassure them that everything will be all right. Time passes slowly and questions go un-

The authors are, respectively, assistant director and executive director, Henry Ford Hospital, Detroit.

The hostess has a desk near the entrance to lounge. The service cupboard is shown at right of picture.

The lounge is quiet, restful and beautifully decorated. It is informally arranged for the convenience of individuals or small groups of people.



Adjacent to the lounge, and yet a part of it, are two chapels, one Catholic (left) and one nondenominational (right). These rooms are properly, though simply, furnished and may be used by anyone at any time for meditation or for participation in the regular services that are held there. They have proved to be of great value to both patients and staff.

answered; as a result, apprehensions mount. Sitting in a vacant hospital room or reading a newspaper in a crowded lobby does little to ease these tensions. Certainly, this is a period for sympathetic understanding on the part of the hospital and its staff.

At Henry Ford Hospital, Detroit, we have found what we believe is a solution to this problem. Although our solution is experimental, we have been quite satisfied with the results.

A year ago we converted an area adjacent to our new operating rooms into a pleasant lounge with comfortable modern furniture, and soft lighting and a cordial atmosphere. It is located at the center of the surgical floors and is readily available to the main lobby by elevator. Families of patients in the operating room are invited by their surgeon or head nurse to wait in this area while surgery is being performed.

Adjacent to the lounge, and yet a part of it, are two chapels, one Catholic and one nondenominational. These rooms are properly, though simply, furnished and may be used by anyone at any time for meditation or for participation in the regular services that are held there. The frequency with which patients and their families, as well as our own staff, have used these chapels has been an indication to us of their value.

The lounge itself is attractively decorated in pastel and neutral tints, with draperies and a carpeted floor. It is quiet and restful. The furniture is so arranged that small groups may converse without bothering others, or an individual can be alone if he desires. Several writing desks equipped with stationery are available, and a phonograph supplied with long-play records adds soft background music. Current magazines and newspapers are provided.

One of the keys to the success of this area is the hostess, who is stationed there full time. It is her function to make the members of the family comfortable and to put them at ease. This demands a sympathetic understanding, combined with maturity of judgment and a real desire to be of help. She sets the mood and makes the whole plan vital.

Among the facilities available to help her in her job are a small refrigerator and a service cupboard, from which she serves fresh coffee and orange juice at intervals during the day. For those who become ill or faint during their wait, she has a small side room equipped with a couch where the person may lie down in seclusion. A doctor is always near at hand to assist, and a supply of blankets and simple medication is available if required.

HOSTESS ACTS AS INTERPRETER

The hostess also is in constant contact with the operating rooms so that she can trace the progress of the patient readily and easily. She must be familiar enough with medical terminology and surgical procedures to interpret that progress to the family. She also makes all of the arrangements for an interview between the surgeon and the family immediately following surgery. The acceptance of this area by our medical staff and nursing personnel has been excellent. In many cases, the surgeon can be helped in his postoperative interview with the family by advance knowledge of their reaction, as observed by the hostess. The floor nurse is usually unable to observe the progress of the patient in the operating room or recovery room and, therefore, cannot properly relay this information to the family if it is waiting on the floor. Because the surgical lounge is near the operating room where the patient's condition can be easily reported, the floor nurses feel that the morale of those waiting is greatly improved.

One of the problems we have encountered in the operation of this room is that it is not large enough to accommodate the families of nonsurgical patients Word that this facility exists has traveled to the medical and pediatric floors, and the hostess often is called upon to use the utmost tact in refusing the use of the room. Of course the chapels are available to everyone.

The idea for such a lounge is not original, but we think its actual function is unique. It is not used by all families and is not forced on anyone. In actual practice, only about half of our families take advantage of it.

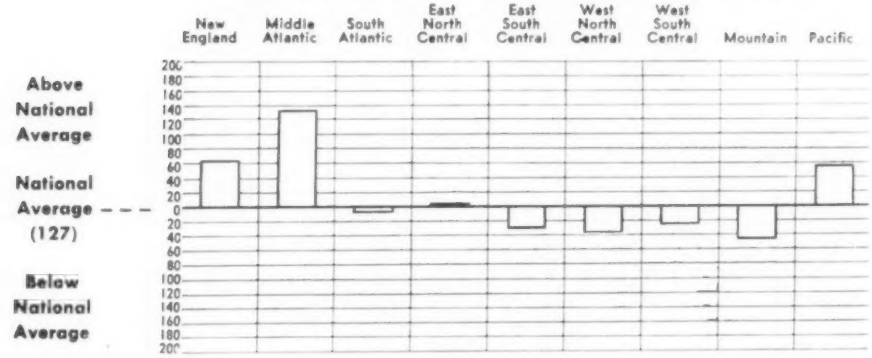
The measurement of success in any program such as this is the reception accorded it by the public. The provision of this lounge is a small service which is unexpected and, therefore, doubly appreciated. The men and women who have waited in this room are enthusiastic about their experience at the hospital. They are grateful for the interest shown in them at a time when it is needed. And a grateful patient and his family are the best good will ambassadors that a hospital can have.

Regional Variations in Hospital Statistics

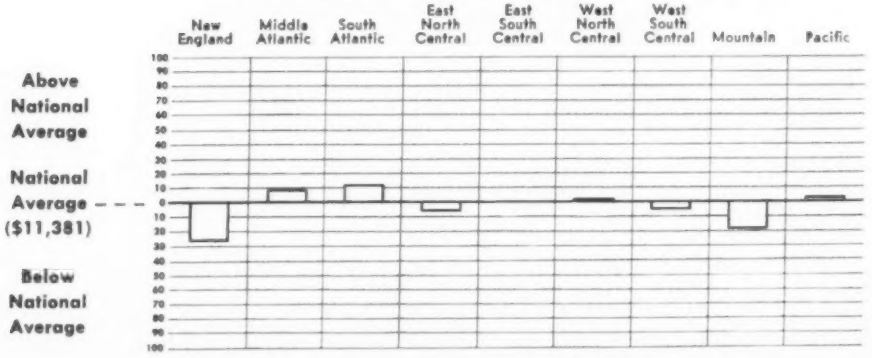
This study shows regional variations among governmental short-term general and special hospitals as to size of hospital, total assets per bed, plant assets per bed, expenses per patient day, payroll per patient day, and the number of full-time personnel employed per 100 patients

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

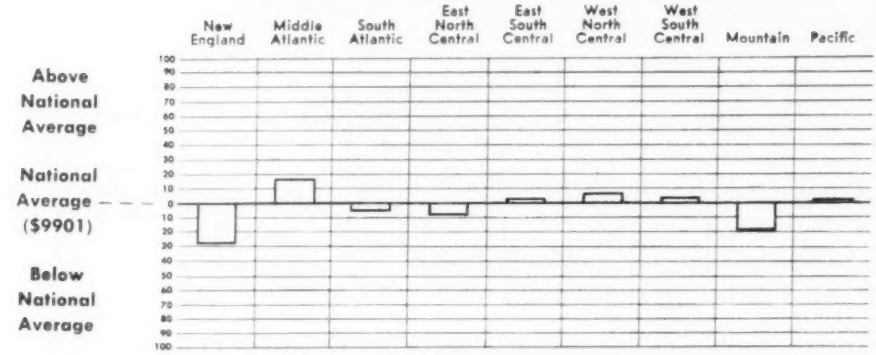
SIZE OF HOSPITAL (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average (127 Beds)



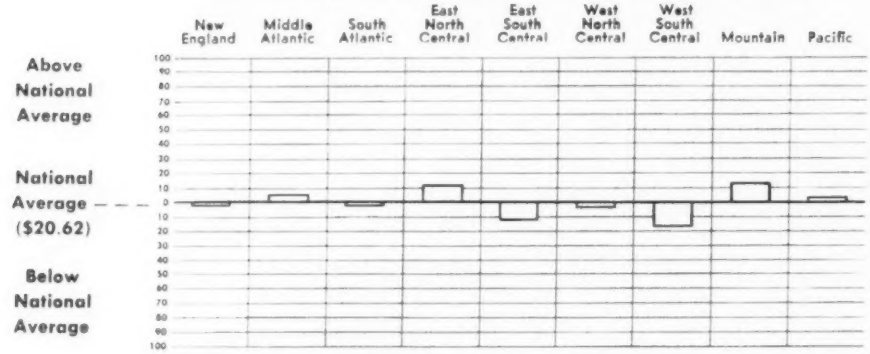
TOTAL ASSETS PER BED (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average ($11,381)



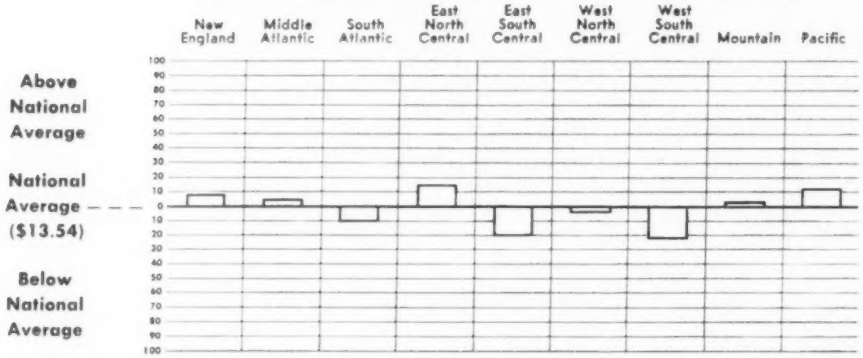
PLANT ASSETS PER BED (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average ($9901)



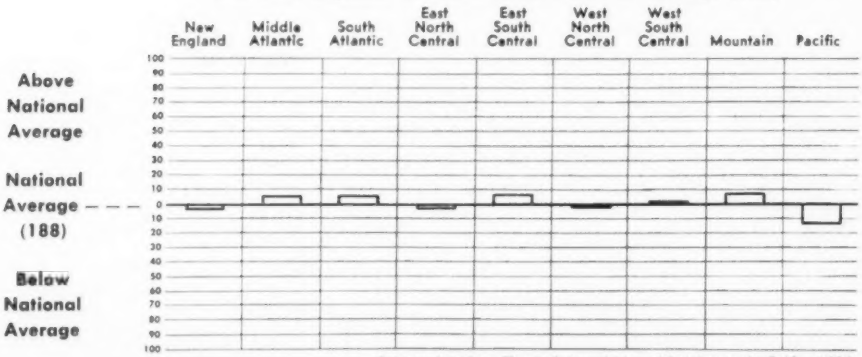
EXPENSES PER PATIENT DAY (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average ($20.62)



PAYROLL PER PATIENT DAY (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average ($13.54)



FULL-TIME PERSONNEL PER 100 PATIENTS (Governmental Short-Term Hospitals)
Per Cent Regional Variation From National Average (188)



Source: American Hospital Association, Administrator's Guide, 1956.

ABOUT PEOPLE

Administrators


John M. Danielson

John M. Danielson, administrator of North Shore Hospital, Manhasset, N.Y., has been named administrator of Evanston Hospital, Evanston, Ill. He succeeds **Arkell B. Cook,** whose appointment as executive director of Butterworth Hospital, Grand Rapids, Mich., was reported in the March issue of The Modern Hospital. Mr. Danielson formerly was assistant to the director of Johns Hopkins Hospital, Baltimore, and assistant director of Roosevelt Hospital, New York. He is a graduate of the University of Minnesota School of Hospital Administration and a member of the American College of Hospital Administrators.

Evelyn T. Farnsworth has been named administrator of Benjamin Stickney Cable Memorial Hospital, Ipswich, Mass., succeeding **Edna M. Hayward,** whose retirement was announced in the March issue of The Modern Hospital. Mrs. Farnsworth formerly was assistant administrator of the Boston Dispensary and Rehabilitation Institute, units of the New England Medical Center, Boston; she was nurse organizer and director of the Pratt Diagnostic Clinic of the medical center in 1942. During World War II Mrs. Farnsworth served with the navy nurse corps, holding the rank of lieutenant commander. In 1947 she organized and directed the nursing service of the American Red Cross blood program in 60 regional centers. She holds master's degrees in nursing and in hospital administration from Yale University, where she once was a clinical instructor in the school of nursing.

John C. Van Metre has been named administrator of Opportunity Home and Hospital, Toledo, Ohio, following the resignation of **Samuel White Jr.** Mr. Van Metre, who received his master's degree in hospital administration from the University of Chicago, previously was administrator of the Northern Indiana Children's Hospital, South Bend, Ind. He is a member of the American College of Hospital Administrators and the American Hospital Association.


Robert S. Hudgens

Robert S. Hudgens has resigned as administrator of Lynchburg General Hospital, Lynchburg, Va., to become director of the school of hospital administration at the Medical College of Virginia. He also was appointed to the newly endowed Arthur Graham Glasgow Chair of Hospital Administration in the college. Mr. Hudgens, who has been administrator of the Lynchburg hospital for 10 years, was associated with the Medical College from 1944 to 1947 as director of the hospital division. He is a fellow of the American College of Hospital Administrators, has been a trustee of the American Hospital Association, and has held numerous offices in the hospital field.


Dr. M. Rosenzweig

Dr. Maurice Rosenzweig, who recently resigned as administrator of Mount Sinai Hospital, Milwaukee, has joined the staff of the Veterans Administration hospital in Pittsburgh in an investigation project of the care of the chronically ill. Dr. Rosenzweig has been president of the Milwaukee Hospital Council and a member of the board of directors of the Wisconsin Hospital Association. He is a fellow of the American College of Hospital Administrators.

William B. Calvin has been appointed assistant director of Mountainside Hospital, Montclair, N.J. Mr. Calvin has been assistant director of Muhlenberg Hospital, Plainfield, N.J., for the last three years. Prior to assuming the Plainfield post, Mr. Calvin was administrative assistant at Passavant Hospital, Chicago. He is a graduate of the hospital administration course of Northwestern University, a member of the American Hospital Association, and a nominee of the American College of Hospital Administrators.

Robert C. Moehn, R.N., has been appointed administrator of the newly organized National Convalescent Center, Milwaukee. The center, which will occupy the site and buildings of the old St. Michael's Hospital, will provide nursing and rehabilitative care to long-term patients, including care of the aging. Mr. Moehn formerly was administrative assistant at Milwaukee County Asylum, Milwaukee. He holds the bachelor's degree in nursing from St. Louis University and a master's degree in hospital administration from Northwestern University.

Helen F. Gould, R.N., superintendent of Grundy County Memorial Hospital, Grundy Center, Iowa, has announced her retirement. Mrs. Gould has headed the hospital for five years.

James W. Crary, administrative assistant of Saginaw General Hospital, Saginaw, Mich., has been appointed assistant administrator of the hospital. Mr. Crary took his postgraduate work in hospital administration at Northwestern University.

Earl Mitchell has been named administrator of Massachusetts Osteopathic Hospital, Boston. Mr. Mitchell, who has had nearly 30 years' experience in various eastern hospitals, goes to Boston from the Erie Osteopathic Hospital, Erie, Pa.

W. Vaughn Herrin has been appointed administrator of Methodist Hospital of Central Illinois, Peoria, Ill., succeeding the late **W. T. Smith.** Mr. Herrin has been assistant executive director of the hospital since 1954.

Sister Electa, D.C., has succeeded **Sister Rosaria** as administrator of St. Vincent's Hospital for Women and Children, Philadelphia.

Dr. Chalmer Davee, director of professional services at the Veterans Administration center in Hot Springs, S.D., has been appointed manager of the V.A. hospital in Marion, Ill., succeeding **Dr. Edward A. Welch,** who is retiring from V.A. service.

Grace Heller, superintendent of Sioux Valley Memorial Hospital in Cherokee, Iowa, since 1929, has announced her retirement, to become effective when a successor is obtained. Mrs. Heller holds the record in Iowa for length of continuous service at one institution. She is the longest term member of the Iowa Hospital Association, of which she was president in 1944. She currently is a member of the board of directors of the Associated Blue Cross plan in the Sioux City area.

(*Continued on Page* 188)

THE MODERN HOSPITAL OF THE MONTH

Exterior of the new building of Maine Medical Center, Portland, Maine, which was added to "Pavilion" built in 1929.

Spaciousness Creates a Friendly Feeling

A welcoming atmosphere has been created in both the entrance and nursing units of Maine Medical Center by omitting solid walls and using railings and glazed partitions to separate the public from the staff

ALONZO CLARK

THE Maine Medical Center in Portland is a good example of the growing trend toward centralization of hospital facilities. In other words, we are now building medical centers instead of hospitals. The Maine Medical Center is an association of three old and respected Portland institutions: the Maine General Hospital (1868); the Maine Eye and Ear Infirmary (1886), and the Children's Hospital (1902).

The facilities of Maine General Hospital have been expanded to meet the combined requirements of the medical center by adding a new building, altering the existing buildings, and increasing the capacity of the boiler plant. The individualities of the Eye and Ear Infirmary and Children's Hospital have been preserved as a part of the center by assigning each a floor in the new building.

The new building has seven stories and basement, with structural steel frame and reinforced concrete floors and roofs. The exterior is faced with light salmon colored brick, limestone trimmed. Windows are aluminum fixed and double hung sections, except in the solariums. These are alternating fixed and casement sash.

The new unit contains several unique features which have proved most successful, and which might well become standard for future hospitals. The first such feature is immediately obvious to everyone entering the hospital. It is the open friendly atmosphere of the entrance floor.

The physical requirements are simple; just omit partitions and use railings to separate the public area from the hospital personnel. This is an innovation in hospital design, although accepted practice in banks, and gives both patient and visitor a welcome feeling which inspires confidence.

The friendly feeling of the entrance floor also has been carried out in the nursing units. The public elevators open into spacious lobbies containing the nurses' stations and floor clerks' desks. The adjoining medicine rooms are enclosed with glazed metal partitions to carry out the "open" atmosphere admired by patients and visitors.

Another feature which has pleased the public and helped to improve hospital efficiency is the outpatient operating suite. (*Text Cont. on Page* 84)

OUTLINE OF CONSTRUCTION COSTS (NEW BUILDING)

Total project cost		**$2,657,400.00**
Number of beds	**111 (planned for 21 additional)**	
Total square feet	**110,000**	
Square feet per bed	**750**	
Cost per square foot		**20.40**
Total cubic content	**1,205,000**	
Cubic feet per bed	**8,200**	
Cost per cubic foot		**1.85**

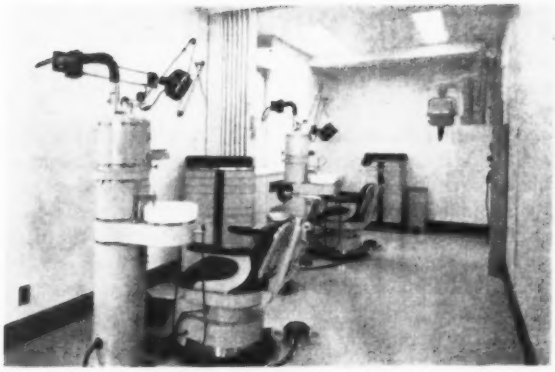
The author is an architect in the firm of Voorhees Walker Smith & Smith, New York. Consultants were Basil C. MacLean, M.D., and interior decorators, Smyth, Urquhart and Marckwald, New York.

Main lobby looking toward the business offices. Low partitions separating the public from hospital staff, widely used in banks, are an innovation in hospital design.

The coffee and gift shop is exceptional in its size, convenient location and decor. The colors and special wallpaper were chosen to enhance the out-of-doors feeling.

GROUND FLOOR

The ground floor contains the outpatient department, which also extends to the first floor. The old pavilion has been altered to provide an orthopedic clinic and emergency unit.

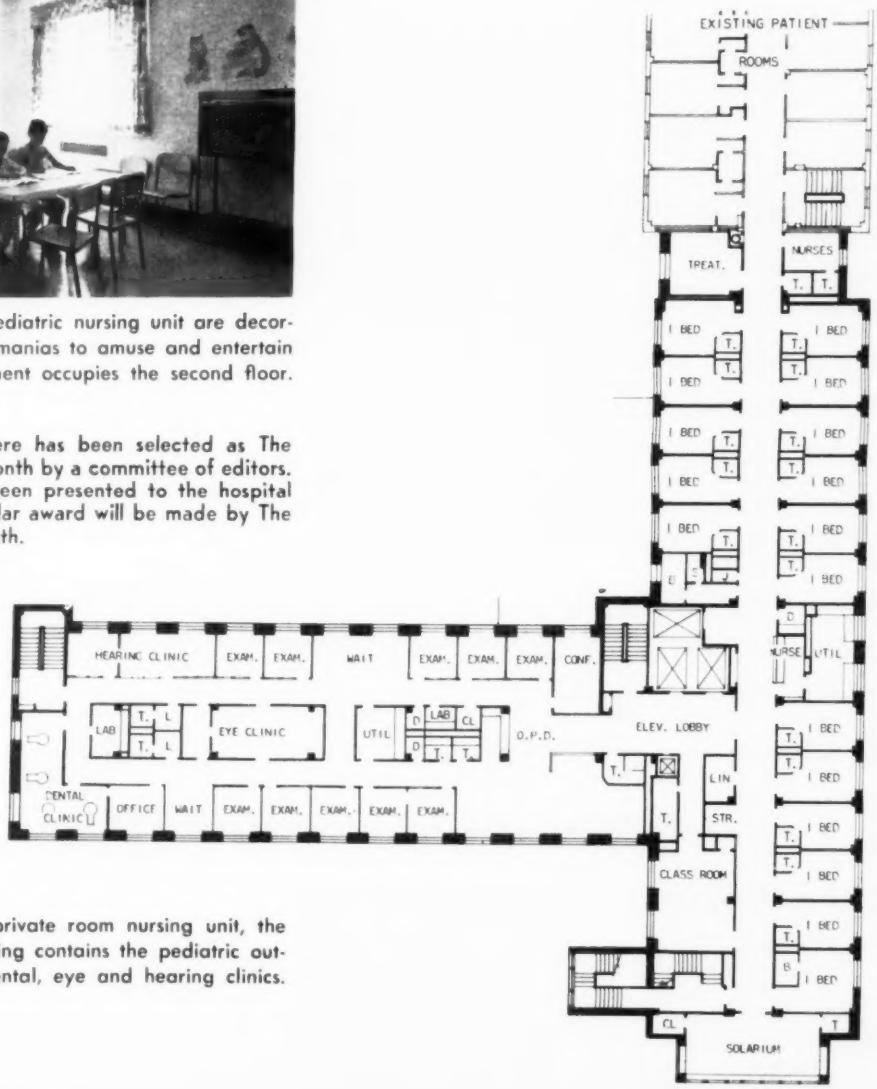


The dental clinic is equipped with two chairs which can be separated by folding partition. The movable x-ray unit shown at right is designed for use with either chair.

Glass and metal furniture give the solariums a light, airy feeling. Solariums have been equipped with oxygen and vacuum outlets and nurses' call for possible emergency use.

The pediatric clinic and pediatric nursing unit are decorated with colorful decalcomanias to amuse and entertain the children. This department occupies the second floor.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by The Modern Hospital each month.



FIRST FLOOR

In addition to a 17 bed private room nursing unit, the first floor of the new building contains the pediatric outpatient department with dental, eye and hearing clinics.

HOW THE MAINE MEDICAL CENTER WAS PUT TOGETHER

DONALD M. ROSENBERGER

OUR planning lasted eight years and continued until we opened the doors to the public several months ago. It is safe to say that any governing board should expect to be at least three years and possibly not less than five years in this stage of effort.

The planning should be broad. The building should please the public that will use it, the doctors who staff it, and the people who assist these groups by maintaining and operating it. The accent must no longer be on beds alone. Many patients will come to the hospital solely for clinical outpatient services such as x-ray therapy, laboratory tests, psychiatric and physical therapy, rehabilitation and a host of other services.

Granted, you say, the community and its needs should be part of the planning. Who knows what these needs are and how they are to be met? We found at the outset that nobody knew the whole answer, but that certain groups knew parts of the picture.

In communities with more than one hospital there often exists a hospital council, which permits study of available services. Community fund raising groups, councils of social agencies, county medical societies, regional and state hospital planning boards, all can supply authoritative information about community needs.

Within the hospital organization, the medical staff and the administrator should supply leadership in crystallizing professional needs. The suggestions of heads of departments, such as nursing, accounting, pharmacy, maintenance, housekeeping and the like, acting through the administrator, are of value in determining what is needed in any expansion program.

To help bring together the original thinking of these various groups in Portland, eight years ago a consulting

Mr. Rosenberger is director, Maine Medical Center, Portland. The article is condensed from a paper presented at the New England Hospital Assembly, trustee section, March 1957.

FOURTH FLOOR

The fourth floor has been assigned to maternity and obstetrics. It comprises three delivery rooms, an obstetrical operating room, and a 14 bed private room nursing unit.

Left: Doctors' examining room outside the nursery on the fourth floor. The nursery has 20 bassinets.

Left: The nursing stations, including floor clerks' desks, and medicine rooms are opposite the elevators.

firm was retained to make a communitywide survey and present general recommendations. A hospital consultant was subsequently retained by the board and worked with the administrative and medical staffs and building committee to develop a functional program. Architectural services were contracted for after the hospital consultant's specific recommendations were accepted by the governing board.

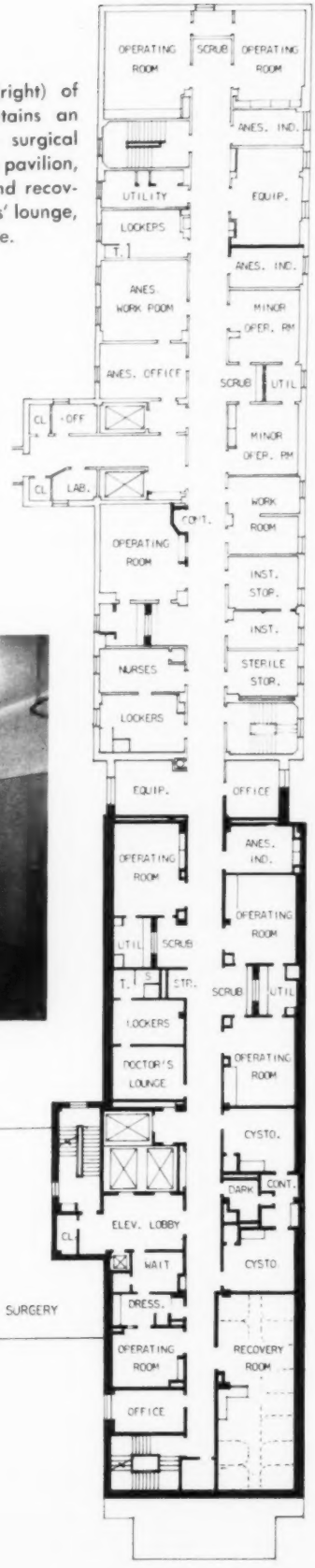
Professional fund raising counsel should enter the picture when the functional layout is static. Funds will be raised satisfactorily only after adequate interpretation of your effort is made to the community.

With a fund campaign in progress or completed, a functional layout approved by all interested groups, and the building committee engrossed in the engineering details with the architect, the next phase is one of setting new objectives to meet requirements of the enlarged organization. Along with this goes a new definition of

(Continued on Page 84)

FIFTH FLOOR

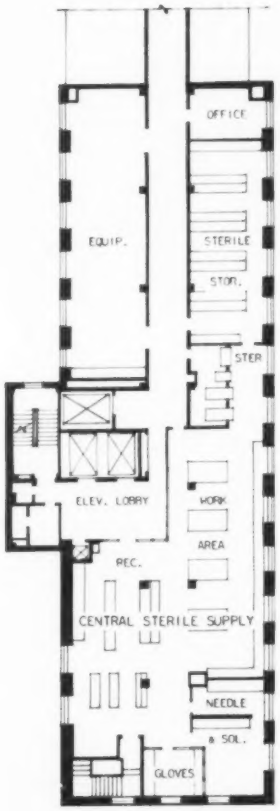
The fifth floor (right) of new section contains an extension of the surgical department in the pavilion, with operating and recovery rooms, doctors' lounge, and surgery office.



Above: The recovery room on the surgery floor contains 12 beds. It is located so that it can be used by outpatients operated on in the special outpatient surgery across the corridor.

SIXTH FLOOR

The central sterile supply room is located on the sixth floor immediately above the surgery. It includes space for equipment storage and repair and an office and conference room.



How Medical Center Went Together

(*Continued From Page 83*)

responsibilities of governing board, administrator and chief of staff.

In conjunction with the establishment of new objectives, of course, current practices in operating the institution must be reevaluated. There is no set time for this, but in our experience all existing departments were reorganized and new departments were organized and functioning, some with new equipment, well before the move.

In our planning we realized we wanted to improve our food service and provide for psychiatric therapy, inhalation therapy, more efficient laboratory service, more specialized care for critically ill patients, postanesthesia recovery room, and facilities for 30 clinics with an anticipated 30,000 visits per year.

In addition to integrating all but the postanesthesia recovery room and the additional clinics into the existing organization, we also added in a basement corridor, on a demonstration and practice basis, a central sterile supply department, an inhalation therapy department, a medical radioisotope unit, and installed new building equipment in the existing x-ray department and operating rooms, although one of these two departments was to be moved in its entirety and the other was to be completely remodeled.

Adding new services and working with new equipment to keep pace with medical advances guided us in our functional and departmental reorganization. All this occurred simultaneously with the development of our architect's plans and during the construction period.

Now for the matter of equipment. One reason for buying and using selected items of new building equipment in advance of construction was so that the public need not be forced to wait for completion of the new building to have the benefit of the advances represented in them. It is important to study and experiment with much of the basic equipment in relation to new building purchases so that equipment will satisfy the departments concerned.

We bought six different makes of hospital beds, chairs and other patient room furniture, and asked our nurses and doctors to experiment with each under a controlled situation on one nursing floor. The cheapest bed was $90. But when the doctors and nurses alike voted for a motor-driven variable height bed costing $250, and our consultant explained patient safety and other factors in its favor, our board bought it. I think this illustrates the principle of joint planning and experimentation very well.

We also built a patient's room the size and dimensions of one designed for our structure. In a short time we learned that a corner trimmed off the bathroom greatly aided the manipulation of a stretcher to the bedside.

At the appropriate time, the services of an interior decorator should be obtained. The hospital will be well served by the efforts of a skilled decorator.

A written record of the planning should be maintained as it develops. Changes in layout, objectives and organization should be charted to avoid embarrassment or misunderstandings at some later time.

Public relations must be watched during every phase of the planning. Do not overlook the value of making every reasonable effort to spend locally funds contributed in your own community. Poor public relations can impair the fund effort and community acceptance of the final structure.

Hospital of the Month

(*Continued From Page 79*)

Located on the surgical floor, it is entered directly from the public elevator lobby into a small waiting room with toilet facilities. A room between the waiting space and the operating room has a dressing booth for patients and a scrub sink for doctors. A sterilizer for doctors' instruments is provided in the operating room.

A door connecting the operating room with the surgical corridor provides access for nurses and technicians required by the doctor. It also provides complete flexibility for use of the room by inpatients when it is not scheduled for outpatients. One other advantage is its location, across the corridor from the recovery room for emergency use by outpatients.

The coffee and gift shop, although more of a standard feature of hospitals today, is exceptional in its size, convenient location and decor. A small but efficient kitchen serves a large cheerful dining area, seating approximately 48 people. There are also 14 stools around the soda fountain bar. Two walls of the dining area are glass, opening on the court formed by new and old buildings.

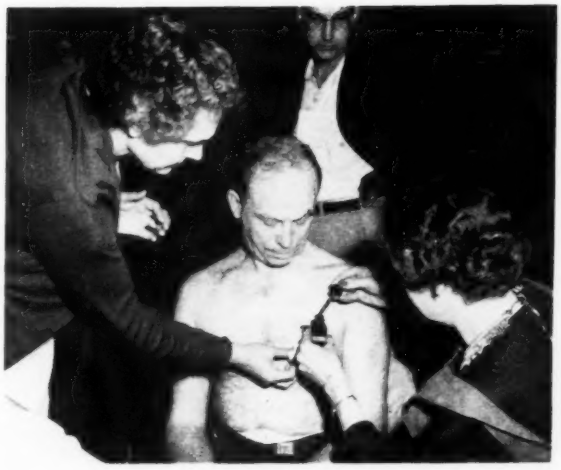
The entrance lobby and administrative areas have mineral acoustic tile ceilings. The lobby is paneled in rift oak and lighted by specially designed fixtures. Lighting in other public areas is by recessed fluorescent fixtures. Corridors and outpatient areas have metal pan acoustic ceilings with recessed lighting.

Walls generally are painted plaster. Bright pastel tints are used throughout the hospital to accentuate the cheerful atmosphere of the "open" planning. The pediatric clinic and pediatric nursing floor are decorated with colorful decalcomanias.

Linoleum wainscots are used in areas of heavy wear, such as stretcher alcoves, equipment storage on surgical floor, and corridors of the emergency department. Outpatient examination and treatment rooms utilize metal partitions to provide for future rearrangement with minimum cost and inconvenience.

The new building is heated by a differential vacuum system with outside compensating controls. The addition of a high pressure "package" water tube boiler, with steam atomizing oil burner, to the existing boiler plant meets all of the normal steam requirements for the medical center. The three small boilers have been renovated to provide stand-by and off-season service. The improved efficiency of the new boiler has resulted in a marked savings in fuel bills. The oil consumption after the new building was completed has increased only 10 per cent over the former rate for the Maine General Hospital. Space for the new boiler was made available by removing existing oil storage tanks in the original coal bunkers, and installing new oil tanks outside the building.

A cooling tower on the roof supplies chilled water to individual remote air handling units in the new building and the pavilion. Complete modernization of existing surgical rooms, including air conditioning, is planned for the future.



1. On Oct. 24, 1956, the "Day of Disaster," one of 28 volunteer victims acquires a superficial chest wound in preparation for disaster exercise. This month's cover photograph shows one of the victims receiving oxygen from a member of the staff of Fairview Park Hospital.

How Do You Know Your Disaster Plan Works?

No matter how well a disaster plan looks on paper, it is worth no more than the paper it's written on until a full-dress demonstration has been put on to show what really happens and where the "bugs" are

THOMAS D. GRIFFITHS

WHETHER a disaster demonstration is military, industrial or civic, the critique that follows is valuable to the participants. If we were to assign a priority of importance to the various events in a demonstration, the critique would undoubtedly be tabbed No. 1.

Such was the case following the disaster demonstration, cosponsored by the Cleveland Academy of Medicine and Cleveland Hospital Council, last October 24 which was developed for some 200 hospital, fire, police, civic, and U.S. Coast Guard observers in northeastern Ohio and carried out at NACA Lewis Flight Propulsion Laboratory.

(*Continued on Page* 88)

Mr. Griffiths is executive secretary of the Cleveland Hospital Council.

2. Realistic arm fractures with extreme flesh searing are applied to victims in deep shock by Red Cross workers.

3. American Red Cross casualty make-up assistants are a bit shocked by the realism of the patient's "burns."

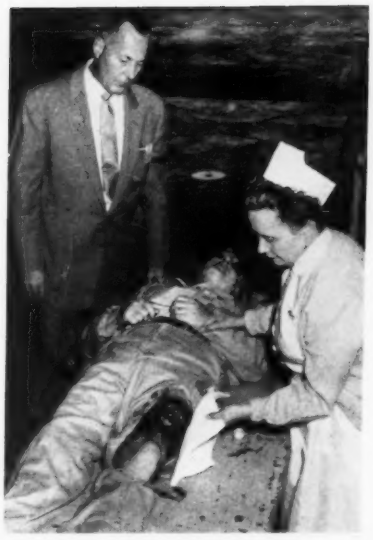
MASTER DISASTER PLAN—NURSING DEPARTMENT

AREAS	RESPONSIBILITIES	PERSONNEL TO BE ASSIGNED (Depends on Needs)	
O.P.D. Waiting room	(1) Receive and sort patients (2) Write identification tags (3) Transfer all patients to: (a) First-aid stations (b) Auditorium (c) Morgue	Supervisor Aux.	1 4
O.P.D. Treatment rooms	(1) Give first aid (2) Complete tag (3) Transfer all patients to: (a) Auditorium (b) Discharge station	H.N. or Inst. Nurses Aux.	1 4 4
Emergency room	(1) Give first aid (2) Complete tag (3) Transfer all patients to: (a) Auditorium (b) Discharge station	(Inst.) Supervisor H.N. Nurses Aux.	 1 1 3 3
AUDITORIUM	(1) Receive all patients not discharged after first aid from ER & OPD (2) Transfer patients to: (a) Nursing unit—5th W. (b) X-ray (c) Lab (d) OR (e) Morgue (f) Discharge station (3) Maintain master control sheet of all patients (4) Give immediate emergency treatment only (5) Care for patients' valuables and clothing (6) Obtain dressing carts (7) Start charts on patients to be admitted (8) Call 5th W. for needed beds	Supervisor Nurses Aux.	1 9 4
MORGUE Conference Rms. No. 1 & 2	(1) Receive all DOA and patients expiring as a result of the disaster (2) Complete tag and keep (3) Care for pts. clothing and valuables (4) Assist relatives in identification	(Inst.) Supervisor Aux.	 1 4
Discharge	(1) Immunization (2) Complete and collect tags (3) Keep house pts. charts discharged because of disaster	Nurses	3
5th Floor—West	(1) Obtain house doctor's discharge or transfer order for all patients (2) Discharge and transfer when called from supervisor in auditorium (3) Prepare beds for adm.	(Inst.) Supervisor Aux.	 1 4
Nursing office	(1) Assign personnel (2) Manual operation of elevators (3) Keep pool for re-assignment (4) Answer phones-errands	A.D.N. Serv. Aux.	1 3
General float	(1) Check all disaster area stations and report needs to N.O. (2) Check all nursing units to reassure and assist (3) If necessary make inpatient rounds	Dir. of Nursing A.D.N. School	1 1

6. Above: NACA nurse assists victim of penetrating chest wound to Cleveland air taxi helicopter, summoned from air terminal.

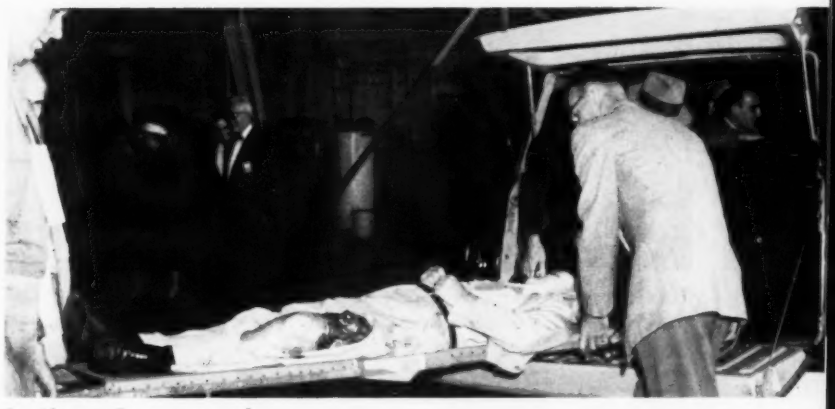
9. Opposite Page: All patients able to walk are tagged by a disaster worker as to name, sex and preliminary diagnosis before they are sent to the proper unit for treatment.

4. Left: The 28 volunteer victims of the disaster (either accident or caused by enemy attack) are given first aid in the main hangar of NACA Lewis Flight Propulsion Laboratory where the disaster occurred.



5. Right: NACA nurse prepares a seriously wounded employe for transportation to Fairview Park Hospital.

7. Below: Two minutes after the nurse escorts her patient to the air taxi, it is airborne and on its way.



8. Above: Every type of transportation—ambulances, station wagons and private cars — is used to take patients to hospital.

10. Below: Some 200 observers from 42 hospitals in Cleveland and environs and fire, police, civil defense and coast guard officials and the press assemble in the auditorium.

11. First casualty arrives at landing area adjacent to hospital. In real emergency it would land on roof or lawns.

12. Patient suffering from chest wound is removed from helicopter to stretcher as he shows signs of "shock."

13. Not far behind the helicopter came the ground vehicles. A victim is removed on a stretcher from a station wagon.

14. Patients not seriously enough hurt to need stretchers, but who still cannot walk, are met with wheel chairs.

(*Continued From Page* 85)

The "all clear" signal was given at 3:30 p.m. Representatives of Fairview Park Hospital, the National Advisory Committee for Aeronautics, the Disaster Relief Committee of the Cleveland Academy of Medicine, the Civil Defense Committee of the Cleveland Hospital Council, the American Red Cross, the local press and the observers reconvened in Fairview Park's Vollmer Auditorium.

Representatives of the participating agencies formed a panel to answer questions which were evident from the notes of the observers.

Because of the realism of the casualty simulation, the question arose as to how training in the art of this casualty simulation might be made available to all concerned. Dr. Harry Haller, chairman of the academy's disaster relief committee, replied that inquiries of this nature should be directed to Kay Gasker, executive secretary to the committee. Mrs. Gasker was trained in this unusual art at the Canadian Civil Defense College of Arnprior, Ont. Incidentally, she holds the only certificate of graduation ever given to an American. If enough interest was evidenced by the area's hospitals, Mrs. Gasker and the American Red Cross, which also trains in the art of casualty simulation, would cooperate in providing the skill.

The technic of organizing and notifying emergency medical teams came up for extensive discussion. The observers were assured that interested hospitals could obtain the cooperation of the Academy of Medicine. Fairview Park Hospital's disaster chairman agreed to make available background data and descriptive material on the operation of the hospital's tried and proven plan.

Could the patient flow be short-circuited especially for these emergency victims requiring immediate surgery? This question is a natural one and, of course, was expected. It was the consensus of the disaster experienced personnel that a question of this type emphasized the value of the critique following disaster drills. Only repeated drills and, of course, repeated critiques can definitely determine the best emergency patient flow for any specific hospital.

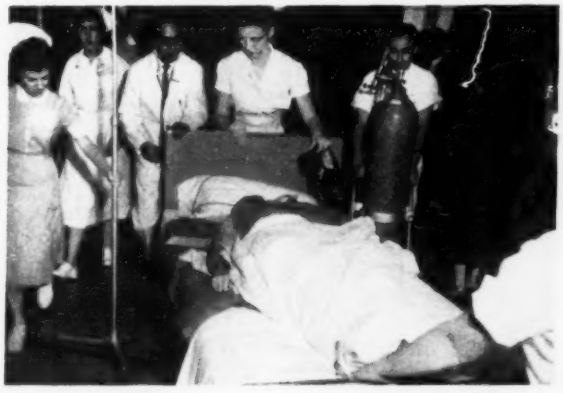
Another topic which came to the front was the matter of expediting the discharge of disaster victims who required only first aid. Any disaster naturally imposes a great many people on the hospital area. Additional people, no matter how well intentioned, can cause a decrease in efficiency. It was recommended that this problem be made the object of a special study. The desired optimum would be the realization of a plan wherein all persons not specifically required in caring for the victims be evacuated immediately after their services or presence were no longer required.

When a hospital has reached its bed capacity, how do you make room for the disaster victims? The Fairview Park plan establishes priority of evacuation for those patients who can

15. The outpatient department is the sorting station in which tags are checked. Carbon copies are kept for record.

16. Disaster victims are checked by Geiger counter for evidence of excessive radiation before they are admitted.

17. Some of the observers of the exercise take notes of the dispatch of a victim from one point to the next.



18. A nurse holds the shoes of a seriously wounded victim who is being escorted to surgery by staff members.

19. The Emergency Patient Information Center where patients' families gather to hear what has become of them.

20. The critique that summarizes what was good or bad about the disaster exercise is an important part of the plan.

be safely returned to their homes to provide the necessary emergency beds. The diagnostic, elective and recuperating patients would head the list to be moved if this becomes necessary.

An information center was established in the lobby of Fairview Park Hospital.

The victims were tagged as to name, sex and preliminary diagnosis at the scene of disaster. Upon arrival at the hospital, this information was immediately copied on a Civil Defense tag by the emergency admitting personnel. The disposition of the victim was added to the hospital tag such as intensive treatment center, first aid and the morgue. A carbon of this tag was taken to the information center for relative and media information.

The best advice that evolved from this critique was: (1) intelligent planning, (2) frequent drills, and (3) detailed critiques following each drill.

Maybe that day of disaster will never come but if it does you are prepared.

Operating Room Staff Practices Fire Safety

Surgeons, supervisors and operating room nurses work as a team demonstrating how to evacuate patients in the event of fire or explosion in the operating room

LT. ROBERT McGRATH

Hospital Fire Inspector, Chicago Fire Department

Suddenly, it happens! A loud report—a sheet of flame thrusts out. The anesthetist removes face piece, shuts off gases, and draws back. The surgeon gives rapid orders. The circulating nurse moves in, another reaches for a sheet. It can't happen here? Two of these seven doctors and nurses have seen it happen just this way.

Now there is a louder detonation and fire seems to spring out of the floor. Anticipating the worst, the chief surgeon orders immediate evacuation of the whole suite. The nurses move horizontally into the next room, using the sheet as a stretcher to carry the patient. Clouds of black smoke are beginning to fill the room.

There is no refuge in the adjoining room because the spreading fire has already halted an operation and forced doctors and nurses to remove their patient. The patient has been removed to the floor below where a temporary suite is being set up. The nurses swing out into the corridor and head for the stairwell.

Temporary surgery is set up and two doctors discuss procedure to be followed next. The chief surgeon (foreground) is waiting to step up to his patient. The camera has caught the flying nurses delivering the first patient to the temporary unit. The second patient is beyond danger, in safe hands a step or two behind.

AUTHORITIES agree, rightly, that fire and explosion situations in operating rooms should be resolved by the surgeons. I have discussed these matters with quite a few doctors and they agree that little thought has been devoted to any kind of preplanning.

Like the nurses, doctors make no claim of knowing all the answers and they are willing to get in and work on a fire safety project if it shows any indication of promise or durability. As usual, I knew none of the answers so when the National League for Nursing proposed a convention demonstration, doctor and nurse and fireman went into the planning on fairly even terms.

At the first meeting it was decided that we would work with four doctors and 12 operating room supervisors from Chicago area hospitals. On the stage of the Coliseum, site of the convention, two complete operating rooms would be set up, staffed and equipped.

We agreed that our convention session of two hours would be divided into four parts: demonstrating the handling of fire, the handling of operating room patients, the handling of heavy patients, and, finally, three situations drills which included fire-fighting and operating room evacuation.

The first situation included an explosion, fire on the patient, a large fire on the floor, and evacuation to the adjoining operating room with the patient being removed feet first.

The second drill was almost the same except the patient was removed head first and all the necessary equipment was moved with the patient—anesthesia machine, stool, standards, basins, trays and instrument table.

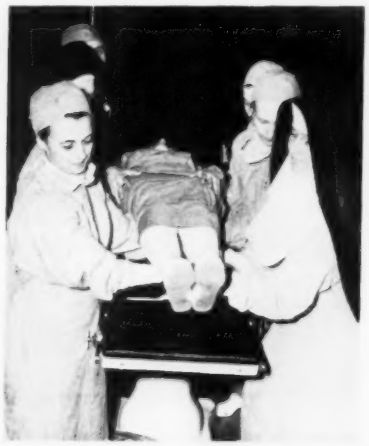
The third situation included fire in both operating rooms, evacuation of two surgical cases down the stairwell, and completion of surgery in a temporary site on the floor below. The doctors told us that the anesthesia machine could be kept off the patient safely for about 60 seconds. The drills were completed and anesthesia was restored in 20 seconds, 29 seconds, and 41 seconds, respectively.

The operating room supervisors were divided into two groups for the training session. Each group worked two hours on fire extinguishing and two hours on setting up specific removal methods. On April 30 and May 2 the two groups joined forces for coordination of personnel, equipment and technics. The doctors moved in also during the second session.

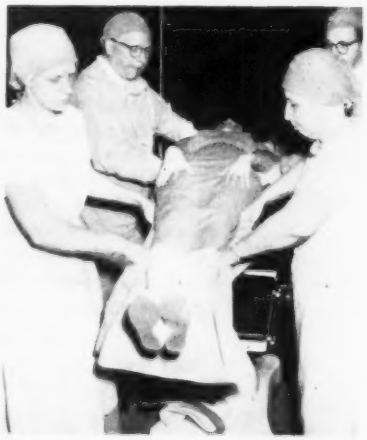
On May 6, the date of our scheduled participation, we went through a morning dress reheasal. The supervisors were skeptical, to begin with, but soon plunged in with all the enthusiasm that lies just behind a nurse's dignity. The doctors were sold on the methods and among us we will keep this movement going.

Nurses attending the convention responded to the demonstration with interest and enthusiasm, and the surgeons agreed these exercises should be conducted regularly in hospitals.

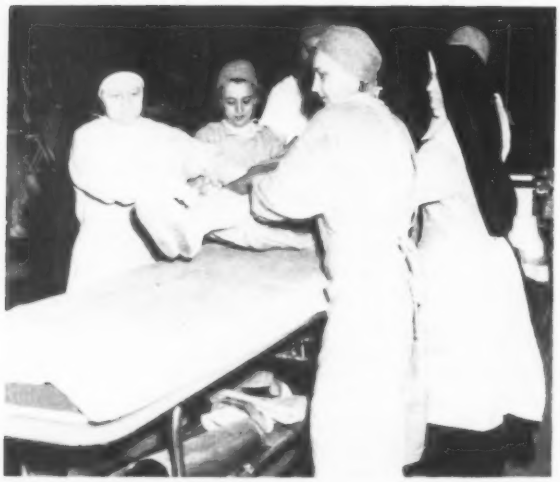
(For additional pictures, see next page)



Right: Operating room supervisors demonstrate placement of hands for removal method which becomes necessary when it is impossible to use the pad sheet as a stretcher. The hands are alternated under the patient, except the two nearest the head. These are interlaced and cupped under the neck. Far right: The removal is made in four counts, the first two audible and the third and fourth understood. One is get ready, two is lift together, three is pivot and four is step off.

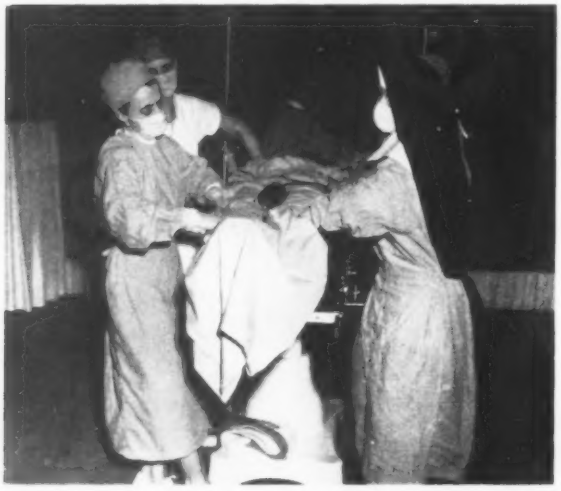


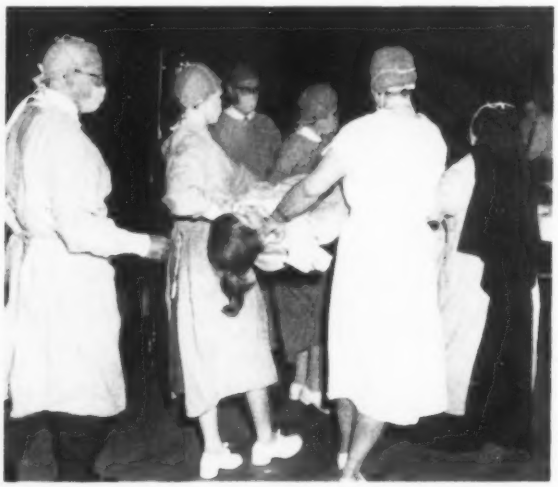
Far left: This is hand placement on the four-nurse sheet carry. The sheet is rolled in tightly against the patient's body so that the knuckles of the nurses are pressed firmly against the flesh. Hands go below the knees, above the knees, against the ribs and above the shoulders. Left: This technic illustrates lifting and removing patient. Again, there are four counts—ready, lift, pivot and move. The first two are sounded off, the other two follow naturally.

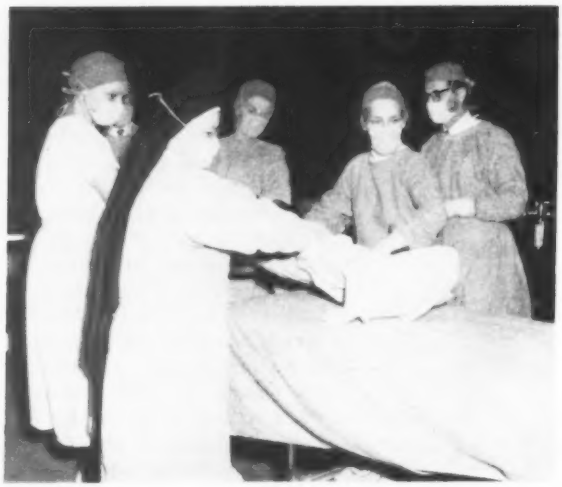


Above: Six nurses can also make the sheet carry. Here the removal is just being completed from table to table. The sheet is rolled in tightly below and above the knees, below and above the hips, opposite the ribs, and against the collarbone. Nurses can go either way, but it is harder to do than four-nurse carry.

Above: This is the six-nurse breakaway. Tremendous weight can be removed from the table by six nurses, but once clear of the table the two center nurses step out and away, free for whatever action is most necessary. There is no change in the rigidity of the patient's posture. Two nurses can also step into the picture.







Above, left: The supervisors employ the four-nurse sheet removal with the patient covered. Blood is taken along to be rehung. Patient is perfectly level. Above, right: Nurses cross from one operating room to another. Doctors remain sterile and are ready to resume the operation. Note that the position of the fists against the collarbone prevents any movement of the head. Left: Nurses spread out preparatory to completing the removal. Doctors start moving into position. The doctors tried out the carries, too.

Problems Multiply at Ironwood Hospital

Three years after a court decision telling the board of trustees to keep its hands off medical practice, the hospital is in worse shape than ever, petitions charge

IRONWOOD, MICH.—The problem that has troubled the people of Gogebic County here for the last three years—what to do about the county's Grand View Hospital?—is now in the hands of a special committee of the County Board of Supervisors, which will try to decide whether the hospital's trustees should be dismissed for incompetence or allowed to continue running the hospital the way they've been doing it since the state supreme court in 1954 ordered them to keep hands off everything having to do with medical practice.

Petitions signed by more than 1000 residents of this and near-by communities allege that trustees have "utterly failed to properly manage or control the administration . . . failed to perform their just duties, and . . . given the hospital a bad name to the community as a whole."

In another petition, 17 doctors asked for a "complete investigation" of the hospital and, if necessary, a new board of trustees. "Conditions at the hospital are deplorable and unwarranted," these doctors declared.

Called in a year ago to study the hospital "to determine the effectiveness of administrative policies," a hospital consultant found, among other things:

1. **More than 1200 incomplete medical records** for the first nine months of 1956, and "as in other matters affecting medical practice in the hospital, no one has authority to require doctors to maintain complete records."

2. **A nursing department operating without unified supervision,** with no one definitely assigned to the direction of this professional work.

3. **No formally organized medical staff** and no regular scientific meetings; no review of case records, and no record of autopsy performance.

4. **A consistent decline in patronage** over a period of five years, with a very sharp decline during the last year.

5. **Steadily diminishing demand on the laboratory** and x-ray departments—"considerably sharper than can be accounted for by reduced patient load."

STEM FROM COURT RULING

Many of those who are petitioning the county board for a new deal at the hospital are convinced that these and other troubles—including a weird episode last winter when the head nurse was fired by the hospital board, then reinstated, but with a former employe as her boss, then fired again—all stem from a 1952 ruling of a circuit court, upheld on appeal to the state supreme court, that the hospital board was without authority to regulate the practice of medicine.

Finding in favor of a plaintiff physician, Dr. Samuel G. Albert of Ironwood, the court ruled that hospital bylaws having to do with hospital privileges, medical records and other aspects of medical practice were illegal under Michigan's Public Hospital Act of 1913 (covering only 7 counties).*

The Act permits a hospital board to make "such reasonable rules and regulations as (it) may adopt in order to render the use of said hospital of the greatest benefit to the greatest number."

In another provision, however, the Act specifically grants to a hospital patient "absolute right to employ at his or her own expense his or her own physician or nurse, and when acting for any patient at such hospital the physician employed by such patient shall have exclusive charge of the care and treatment of such patient."

Following the court decision, the board adopted new rules providing that every patient at Grand View Hospital should have this absolute right. The new rules also added that "the house doctor, the nurses, the laboratory technicians and the employes therein, shall as to such patient be subject to the directions and orders of such physician."

Since that time, Dr. Albert, who insists that the hospital today is in "better condition than ever before," has had things all his own way—a circumstance that has led to some sharp departures from commonly accepted medical records and personnel practices.

Thus, for example, it was a complaint taken directly to the board of trustees by Dr. Albert that led to the discharge of the head nurse, Mrs. Rose Endrizzi, last January, in a maneuver that completely by-passed the hospital administrator, Frank Drazkowski Jr. In a letter to the board, Dr. Albert charged that Mrs. Endrizzi "antagonized my patients . . . refused to follow my orders, and . . . incited other nurses against me."

Mrs. Endrizzi denied the charges categorically, and, following a public hearing that took on something of the character of a poolroom brawl, the board reinstated Mrs. Endrizzi a month

(*Continued on Page* 154)

*Williams, Greer: Medical Anarchy in Ironwood, Mod. Hosp. **82**:51 (April) 1954.

Let the Service Club Serve Your Hospital

More than 50,000 civic and service clubs are ready to help hospitals solve their extrabudgetary equipment problems

JAMES FERGUSON

IT MAY seem paradoxical for the administrator of one of the newest hospitals in the country today to be commenting on how we have been able to get local service clubs to help us equip and set up a plant on which some $6 million has already been spent. But the service clubs and local civic organizations are significant and important enough to warrant this short study of the rôle they are playing in the hospital field today. This is especially true in the light of ever increasing needs for extrabudgetary equipment and community reaction to higher hospital costs.

JAYCEES GO INTO ACTION

Perhaps one of the most impressive and dramatic examples of service club support in a crisis was the action of the Knoxville Junior Chamber of Commerce, Knoxville, Tenn., in 1952, when the city was struck by a polio epidemic. The Knoxville General Hospital, now integrated into our University Center-Hospital, was sorely taxed. In particular, there was a crying need for iron lungs, portable chest-abdomen respirators, hot pack and suction machines. At the time, spare respirators were being flown into Knoxville by the air force from such cities as Atlanta and Nashville.

In typical Jaycee fashion members of the local club decided at a meeting in mid-October of that year, when things looked very black, that they would have to take some action to help the situation. They were assured by the local hospital administrator that certain types of equipment were needed but unobtainable for lack of funds. So they set out to raise the money—lots of it.

Six days after they held their meeting and decided to "do something," the University of Tennessee was to meet the Alabama football team in Knoxville. The Jaycees made a plea to Gen. Robert Neyland, athletic director and coach at the university, to permit them to take up a collection at the game. Recognizing the dire need for help, Gen. Neyland gave his assent. The Jaycees and their wives then had about five days to organize for "Operation Shake-Down." Another limiting factor was the time allowed for the collection. Gen. Neyland said they could have the time at the beginning of the game after the playing of the national anthem and before the kick-off.

Armed with buckets and assisted by 25 state troopers, the 100 Jaycees and Jaycettes took up a collection from some 52,000 spectators in just 12 minutes! Nineteen bulging bags of money were carted off the field. It took two days to count the $10,800 collected. This money was then used by the Jaycees, in cooperation with the Knoxville General Hospital and the Academy of Medicine, to purchase the following: one chest-abdomen respirator, two tank-type respirators, two infant respirators, and two suction and hot pack machines.

In the course of administering this new hospital here in Knoxville, other local service groups have been most helpful. The Lions Club has assisted in setting up an eye clinic. The Cancer Society donated a $13,000 deep therapy unit. The "40 and 8," an adjunct to the American Legion in this city, gives an annual nursing scholarship. Sunday school classes contributed toys, furniture and supplies for the solarium in the pediatrics ward. The Northside Kiwanis Club gave a television set for pediatrics and also made the first contribution for the medical library. The Ladies Garden Club of Knoxville has arranged to provide plants for the solarium.

JOBBERS GIVE X-RAY EQUIPMENT

Although not a service club, the Knoxville Automotive Jobbers Association adopted a service club type of project at Christmas of 1955 by giving, in behalf of their customers, x-ray equipment valued at $2000. The idea was so well received that the organization repeated the performance in 1956, giving $2000 in projectors to use for training purposes. Actually, these gifts represented a diversion of funds that the wholesalers in prior years had allotted for small gifts to be distributed among their customers.

All over the country, as in Knoxville, there are countless institutions that rely heavily on the civic and service clubs for items of equipment that are extrabudgetary. And in these days when hospital costs are steadily rising in the face of a baffled and uncompre-

Mr. Ferguson is administrator, University of Tennessee Memorial Research Center and Hospital, Knoxville.

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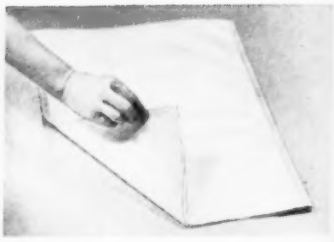

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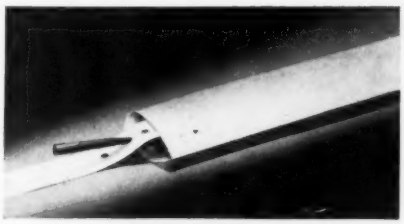

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The portable chest-abdomen respirator was part of the equipment purchased with funds raised by Knoxville Jaycees during the polio epidemic.

hending public, working with community groups serves a twofold purpose. First, of course, is the substantial contribution of equipment, manpower and scholarships they voluntarily provide. But equally important is the support for a hospital and its problems that is won when some local organization undertakes a project for it. The feelings of cooperation, sympathy, understanding and participation are all engendered when people become interested in working for the hospital from the outside.

Since winning this support is an extremely important, and sometimes overlooked, aspect of hospital administration and public relations, it might be useful to examine the activities of a few of the major service clubs in this country and study their basic policies *vis-a-vis* hospital support work.

There are more than 42,000 local organizations connected with these seven groups: Lions, Jaycees, Moose, Elks, Rotarians, B'nai B'rith and the American Legion. Since they are representative of the many other organizations in this country, it will probably be sufficiently illustrative to examine these clubs to get some idea of their power, enthusiasm and contributive potential.

Largest of the service clubs in the strict sense of the word is Lions International. There are more than 12,000 clubs and 400,000 American men in the Lion movement in America, not to mention the tens of thousands in other countries. Of a total of more than 170,000 projects undertaken by the Lions last year, some 20,000 were in support of health and welfare programs. And this cannot be measured only in terms of dollars given. Manpower, community and public relations, and moral support to local health and welfare projects are also to be tallied up in the assets column.

Typical of thousands of projects is the Eye Clinic set up in the Kennestone Hospital of Marietta, Ga. In less than two weeks 79 hustling Lions raised more than $5000 by selling ball point pen and mechanical pencil sets throughout the community. Merchants carried them in their pockets, barbers sold them to their customers, teams went from door to door for the cause of an eye clinic. And everyone who supported the undertaking knew he was doing something to help himself, his own community.

In the December 1956 issue of the international Lions magazine, there were more than 30 club projects mentioned that directly benefited hospitals or individual patients in communities of the U.S. In Silver Lake, Ind., for example, the Lions were not only responsible for the building of a new $20,000 medical building for the community, but even obtained a doctor to staff it.

Another continuing need for hospitals that Lionism is constantly trying to meet is the shortage of doctors and nurses. Literally hundreds of nurses today have their professional training, thanks to the scholarships provided by Lions clubs. And last year the Olin, Iowa, chapter of Lions met the town need for a doctor by actually importing one from Scotland.

The Junior Chamber of Commerce is perhaps the youngest organization in the U.S. in terms of the age of its membership. After 35, members are more or less retired from full club activities. This means there is youth with its vigor, imagination and "can-do" spirit that can be tapped for fast moving crash operations like the one mentioned here in Knoxville when the respirators were purchased. And the nights away from home, attending meetings and conventions and working on projects, have invariably drawn the wives into the picture, too, so that in most cases every Jaycee has a built-in Jaycette auxiliary in his wife.

Each of the 1725 Jaycee clubs in the country is actively engaged in several projects at the same time, and the records show that during the last year more than 17,000 projects were undertaken to assist hospitals and health drives. Some 30 Jaycees of Oklahoma City have had a project for more than a year, visiting the patients in the Oklahoma Crippled Children's Hospital and carrying out special assignments, such as arts and crafts, movies, games and contests, and entertainment. Two trips a week are made to the hospital by these Jaycee entertainment teams and, needless to say, morale has shot 'way up in the wards.

In New Haven, Conn., last year the Junior Chamber of Commerce sponsored a Community Health Week to bring to the attention of the citizens the health facilities available to them. They conducted forums with doctors participating, formed speaker teams to address other civic groups, used TV, radio and the press to publicize their affair, and encouraged shops to put up health exhibits.

The Loyal Order of Moose, 10 years ago, made it mandatory for each of its 1800 lodges in North America to maintain a standing civic affairs committee. The function of this committee was to sponsor a community service program. Carl Weis, director of the civic affairs committee for the supreme lodge, states that hospital support work ranks high on the list of popular activities undertaken by local chapters through this program.

"These activities run the whole gamut, from presenting a small check, to the purchase of an item of needed equipment—all the way up to assuming leadership in community fund raising drives for hospital building funds," reports Mr. Weis.

And what hospital administrator and board member doesn't feel a profound sense of gratification when some worthy community group volunteers to assist in, or even assume leadership for, so necessary, yet oner-

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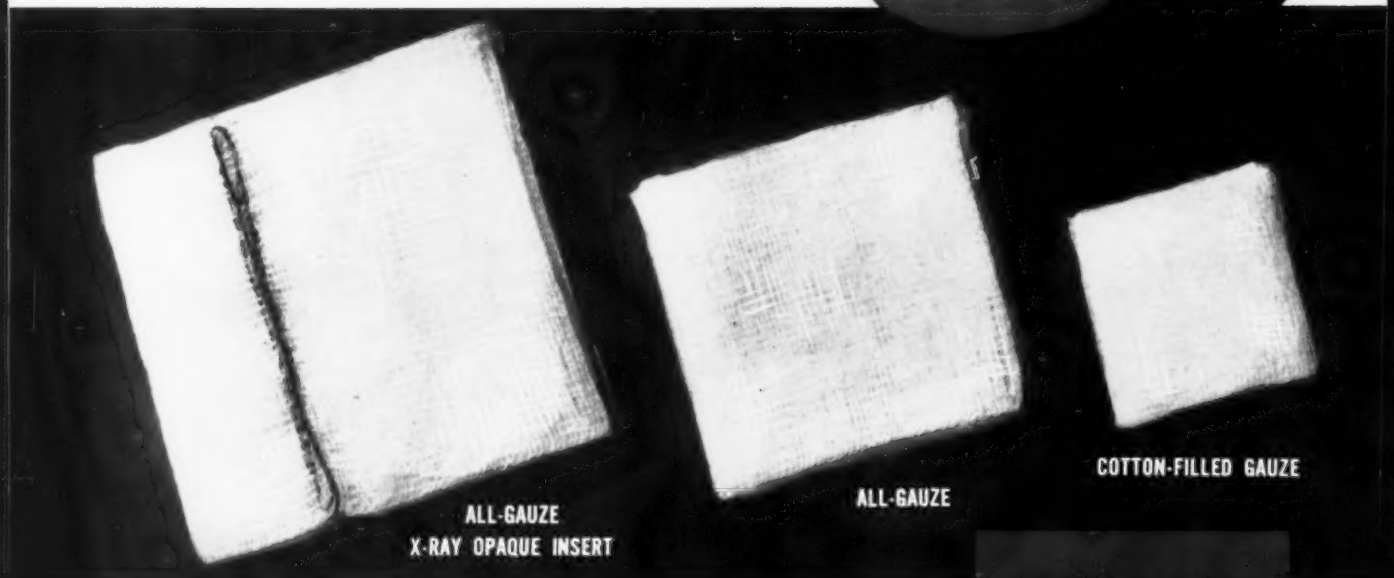

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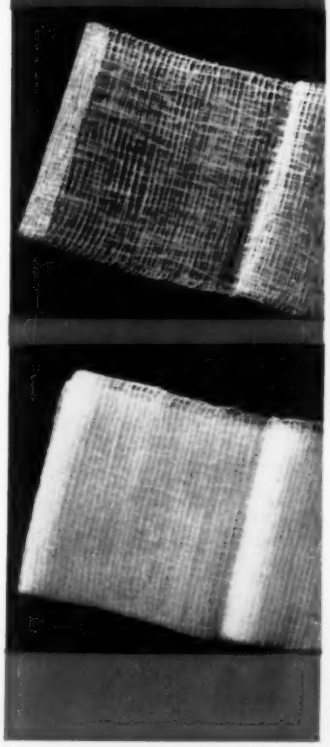

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ous, a job as a fund raising campaign for a building program? This certainly must have been the feeling of the hospital officials in Bellefonte, Pa., during one of their recent drives. The Moose lodge in that town offered to match the combined contributions of all other local organizations—and then delivered $30,000 to make good that pledge. Raising this money had to be done *after* all other organizations had already solicited the town quite thoroughly. And there are fewer than 6000 people in this community!

Activities of the auxiliary, Women of Moose, should get a mention, too. For today, this group is primarily responsible for the nurses' training received by more than a thousand young women throughout the country.

Such activity is a little more easily understood when one realizes that in the Moose ritual there is one pledge all must take:

"Thou shall devote thyself in service to thy fellow men. . . ."

ELKS PAGEANT NETS $80,000

Since 1933, hospitals, institutions and other charitable agencies in Queens, N.Y., have received more than $3,750,000 from the local lodge of another great service organization—the Benevolent and Protective Order of Elks. Climaxing this record was the 1956 Queens Elks "Pageant of Giving" when more than 25 hospitals and institutions shared with other organizations some $80,000. On this occasion, the mayor of New York, Robert F. Wagner, stated that the mounting costs of patient care make it almost impossible to include all needed items in the city budget. He observed that the hospitals were better equipped because of this aid from the Queens Elks.

When one considers the contributions in terms of sustained help through the years, this type of support takes on real meaning. Indeed, many institutions have come to depend on this aid as the only means they have of making progress, what with the many other drains on the budgeted dollar.

That support of this sort will continue is evidenced by the vigor of the Elks national service committee which expends more than a half million dollars annually for programs of cheer and comfort and nonbudgeted equipment in Veterans Administration hospitals throughout the country. Hospitals for crippled children, mobile medical units, and scholarships for cerebral palsy therapists are just a few of the activities of the 2015 B.P.O.E. lodges throughout America.

"After the needs of a community have been determined a club should ascertain what existing agency or agencies are qualified to carry on the work in the community. If one is found, the club should confer with it and determine how the club can cooperate with and strengthen the work of the agency and elicit for it the united support of the community. If no suitable agency exists the club may find it advisable to create a new agency, or otherwise initiate a community venture. . . ."

With a clearly stated policy such as this, it is small wonder that Rotary International, with some 8000 clubs in the United States, has been such a significant force in marshalling public support for hospital programs. The Rotarians of Endicott, N.Y., demonstrated the application of this policy when, in building the new hospital for their community of 21,000, it was decided that another $150,000 was needed to equip it properly. The then hospital chief of staff, Dr. Karl Rundell, an Endicott Rotarian, decided that through Rotarian leadership a fund raising campaign could be launched and the hospital could be provided with these necessities without floating more bonds or imposing further on one especially wealthy benefactor.

The Rotarians brought together all civic groups and formed the United Service Club for Endicott's Ideal Hospital.

Within four months, by combining efforts and subordinating individual club pride to the development of community pride, the additional money had been pledged. In this way, the Rotarians not only took initiative but helped form a favorable climate in the community that encouraged widespread participation in the drive. Thus, leadership and organization as well as actual field work are often contributions that service clubs can be expected to make to hospital development and equipment needs programs.

Across the nation some 400,000 American Jews in 1750 chapters and lodges have been doing community service and citizenship work for 113 years through B'nai B'rith. In every community where chapters and lodges are established, the entire citizenry has benefited from the cooperation and strength of this organization. Typical of the work done is the contribution of manpower, or womanpower, of the Stamford, Conn., chapter. During one of the drives to raise funds for polio, a routine letter was sent by the local polio chairman for a token contribution of $25. The ladies of B'nai B'rith said they didn't like the idea of merely making small token contributions but wanted to do something more.

They offered their time to collect money in theater lobbies for a week. By doing this they were able to turn over more than $2400 to the fund drive—a big difference from the $25 they were originally asked to contribute.

With 2,800,000 members organized in 17,200 posts, the American Legion, world's largest veterans' organization, attributes its growth to the fact that its activities are mostly community centered and community minded.

One of the basic purposes of the American Legion, as set forth in the preamble to the organization's constitution, is "to inculcate a sense of individual obligation to the community, state and nation."

LEGION HAS MANY PROJECTS

This basic purpose, operating within the wide autonomy granted the individual post, has found expression in a multiplicity of activities and projects, variously sponsored by such committees as rehabilitation, Americanism, child welfare, and community service.

Following the close of World War II, communities of every size found their health services inadequate to meet their growing populations and the increasing demand.

Fund raising for hospital construction, the donation of needed equipment, scholarships for nurses, volunteer services for hospital patients, public support of bond referendums, operation of ambulance service, and many other similar activities are examples of American Legion participation in hospital projects.

When the citizens of Indianapolis launched a $12 million campaign to improve and add to the private hospital system of that city, the employes of the American Legion national headquarters in Indianapolis and all members of the American Legion and its auxiliary, organized their own payroll deduction plan, which raised $8159, enough to equip a two-bed room in the new community hospital. This amount was matched by another gift contributed from the funds of the national organization of the Legion itself.

(*Continued on Page* 100)

From these few examples can readily be seen the potential support hospitals everywhere have if these local clubs are approached in the right way. Their contributions amount to millions of dollars annually and their support of nurses' training and research is tremendous. So it would seem important that administrators cultivate these groups properly. But there are several approaches and cautions that it might be well to note here.

First, an administrator always should have in mind a list of needed items of varying magnitudes, *i.e.* an eye bank for a large group such as the Lions Club, or a new bulletin board for the nurses' quarters for a small Girl Scout troop.

In this connection, it has proved to be wise to make sure that the needs cited can serve a number of patients or people, that they are really justified, and that they have a certain appeal to the donor group.

Another important factor that should be taken into consideration is the national projects of many service organizations. The Shriners, for example, have consistently undertaken the project of hospitals for crippled children; the Lions support their sight saving campaign; the Kiwanians in many parts of the country contribute their efforts to fresh air camps. It is, therefore, far more effective to approach a club for help that may be already working on a project that ties in with hospital needs.

If one club is quite busy with a big project that may have nothing to do with hospital support, it is better to look for a club not quite so busy.

Next, it is important to maintain a steady public relations program with the community civic organizations. Included in this campaign are these steps: (1) Be available to speak to luncheon meetings to tell the hospital's story, its progress and problems, and keep up personal contact with these groups at all times; (2) invite groups to tour the hospital occasionally; (3) publicize in the local press and over local radio stations, hospital activities, especially projects involving service club cooperation; (4) direct annual reports of the hospital to the attention of organizations with which it desires to maintain a strong contact.

There are two other proposals that are worth considering in this regard. First, an association of service clubs can be formed to keep interest in hospital activities at a consistently high level throughout the year. And, second, the hospital, through the board of directors, can make an annual award to the service club that does the most outstanding job for the hospital for the year. These serve to keep public attention focused on the hospital and thereby keep a favorable reservoir of community good will from which to draw as the need arises.

One thing should not be forgotten: The initiative for developing good relations with service organizations belongs to the hospital administrator. The activities and policies of the organizations mentioned indicate the degree to which these clubs are willing, even directed, to help welfare institutions and hospitals. It is up to the local hospital officials to "break the ice" with these groups and acquaint them with the services they can perform, the equipment they could provide, and the support they can garner for the hospital from the community.

A short time ago a visitor from Germany was visiting our hospital and was invited to attend the luncheon of the Knoxville chapter of a local civic club. When he heard about the hospital project they were undertaking, he seemed quite surprised. Later he asked about it, and when he was told of the numerous activities and the vast amounts of equipment purchased for the hospitals by civic organizations all over the United States, he expressed great amazement.

"Such a wealthy country as America has to depend on voluntary charity to run its welfare institutions! It is quite a surprise. In Germany, the government plays the major rôle in providing this type of support. I am quite surprised that America should be so unorganized in this matter. . . ."

This is a typical reaction for someone who does not know that even in so vital a matter as equipping and supporting hospitals, America reflects a truly democratic attitude, a genuine community mindedness. It is the individual citizen who benefits from the hospital and its services. And through the thousands of service and civic organizations in his community he voluntarily assumes his share of the burden of helping to provide for needs not met under the straining budgets of today's hospitals. As a hospital administrator I am grateful for their support and proud to be working with some of our nation's finest institutions —the service clubs.

How to Calculate the Laboratory Work Load

The operation study methods reported here are helpful in assigning staff, estimating the work load requirements, and determining laboratory budgets

SEWARD E. OWEN and EDMUND P. FINCH

THE correlation of clinical laboratory staff and diagnostic tests performed involves many factors. Operation study methods in clinical laboratories apparently have not been thoroughly applied or reported. Our experience has shown that a great variety of circumstances and conditions may affect the work output of a clinical laboratory. These operation studies have been of much help in staff assignments, work load requirements, budgetary matters, and in many other problems. The material presented here may stimulate others, lead to improved patient care generally, and to a better understanding of laboratory management.

ELEMENTS OF IMPORTANCE

Among the many factors that may influence technological output, accuracy and adequacy of a clinical laboratory are: the laboratory location; equipment type and layout; traffic patterns; types of patients served; amount of work in each specialty; manner of specimen preparation and collection; meal hours for patients and staff; clarity and timing of work requests; the amount of emergency work; the type of tests done; abilities of technologists and of the professional staff; size of the staff, and, possibly the most important, the director's or supervisor's ability to coordinate these elements nicely and to generate acceptable attitudes in the lower echelons of the staff.

The authors are, respectively, chief of the laboratory section and supervisor, Unit 1 Laboratory, Clinical Laboratory Service, Veterans Administration Hospital, Hines, Ill.

Published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

METHODS AND RESULTS

Despite the scarcity of well qualified technologists, hospital laboratories must produce acceptable output, operate in the most efficient manner, and provide accurate results in the shortest possible time. Using this thesis as a basis, a two pronged investigation was undertaken: First, what comprises a standard laboratory man-hour (SLMH) and how does this standard hour vary from section to section; second, can we establish a series of norms for test output per man-hour (TMH) and what are the variations to be expected here?

After some investigation we decided that the SLMH should be divided into five parts: (1) benchwork—time spent performing actual technical work at the bench; (2) collection time—collecting the specimens from ambulatory and from bed patients; (3) rest and personal needs — this includes paid leave of any type and some time for personal needs; (4) nontechnical time —preparation of reports, telephoning, conferences and seminars; (5) reagent preparation, cleanup of equipment and glassware, checking of stock standards, and so on.

The divisions of the SLMH varied with the specialty, as was to be expected. (See Table 1 and Graph 1 on page 104.)

Benchwork time varied from a high of 46.6 minutes in parasitology to a low of 30.5 minutes in bacteriology. Collection time for the transfusion section was 14.1 minutes as compared to 2.5 minutes for bacteriology. There was nothing significant in the rest and personal needs fraction. This figure is influenced by the number of senior grade workers in each section since these employes receive more annual leave. Nontechnical time was lowest (1 minute) in the hematology section, where comprehensive printed report forms are used, as compared to 5.7 minutes for the urinalysis section where the reports of microscopic examinations are relatively lengthy and handwritten. The bacteriology section utilized 16 minutes of each hour in reagent and media preparation, while parasitology needed only 1 minute, hematology required 1.6 minutes, and biochemistry, 2 minutes.

At this hospital, laboratory examinations are classified by type, regardless of the laboratory section in which they are performed. At the end of each day, data obtained from the report forms are posted on the section work sheets. At month's end, the tests are added and the totals consolidated on a standard monthly report form. On this latter form the various examinations are grouped into nine categories. Six of these categories are general

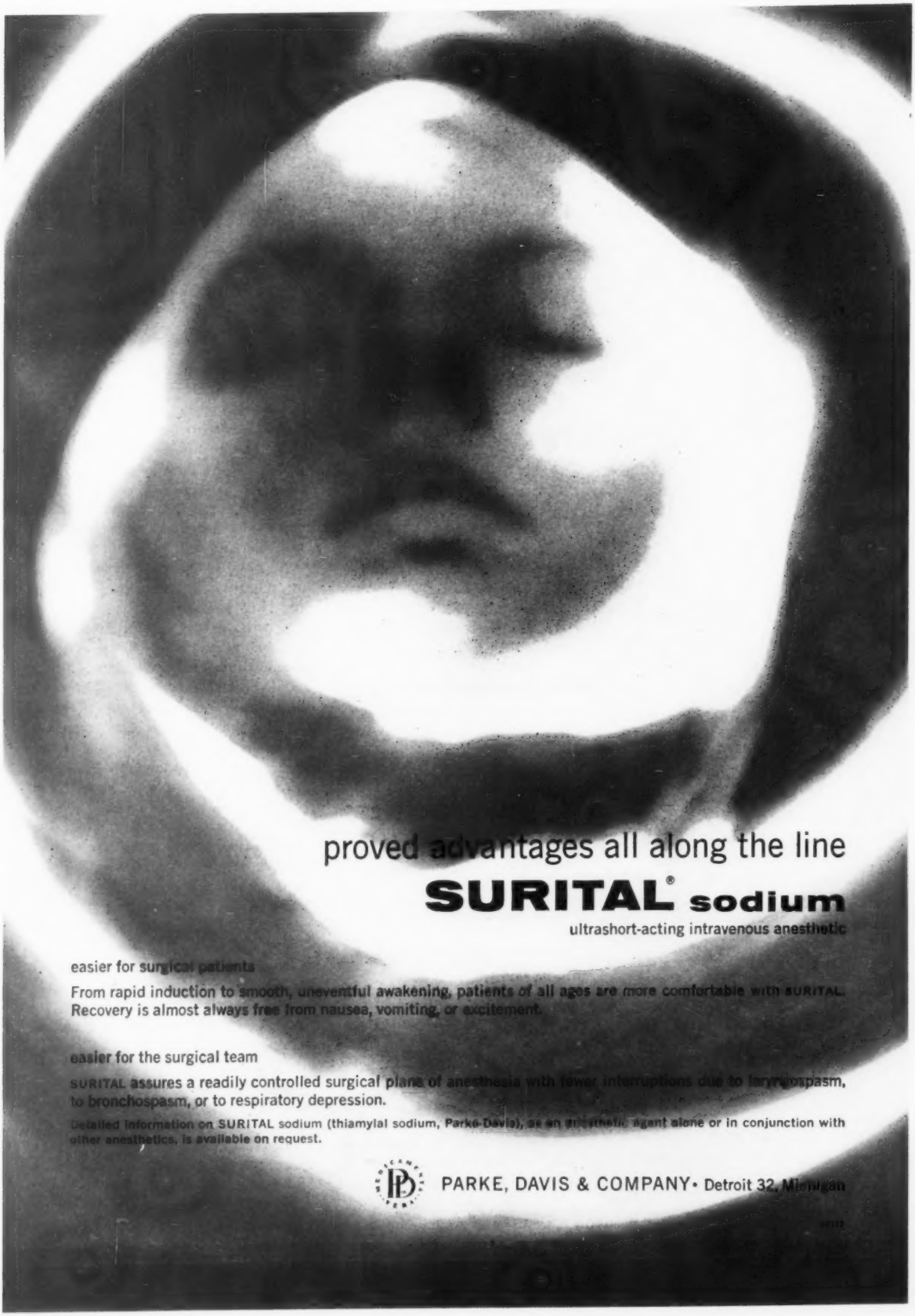
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Table 1—Standard Laboratory Man Hour (SLMH)

Specialty or Unit	Bench Time	Collection Time	Rest and Personal Needs	Non-technical Time	Reagent Prep: Cleanup Time
Bacteriology	30.5	2.5	6.5	4.5	16.0
Biochemistry	44.0	5.3	6.7	2.0	2.0
Hematology	38.6	11.0	7.8	1.0	1.6
Histology	33.7	8.2	7.3	3.3	7.5
Parasitology	46.6	1.2	6.5	4.7	1.0
Serology	34.2	7.5	8.7	3.6	6.0
Transfusion	31.3	14.1	6.1	2.4	6.1
Urinalysis	37.8	4.3	4.1	5.7	8.1
Average	37.5	6.4	6.8	3.0	6.3

The standard laboratory man-hour (SLMH) presents the activities for each hour for each specialty. The minutes utilized for each activity are determined from averages. The "all-lab" average is weighted for the number of technologists in each specialty or unit.

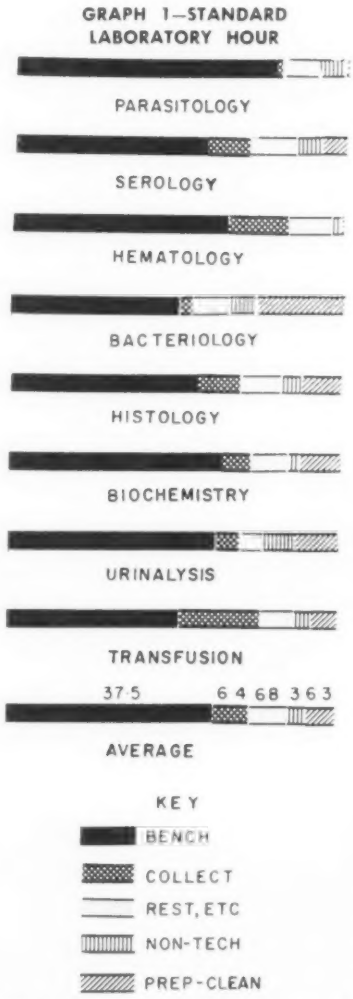
classifications; the seventh is water, dairy products and food analyses; the eighth is toxicology; and the ninth is a general category for tests that do not fit the other groupings—basal metabolic rate testing is an example.

CATEGORIES ARE SUBDIVIDED

Each of the general categories of examination is further subdivided into workable parts; for example, the chemistry category includes blood chemistry tests, qualitative urinalysis, quantitative tests on urine, chemical tests on spinal fluids and other chemical diagnostic tests. Under hematology are listed cell counts, typings, groupings, cross matchings, sedimentation rates, and a catch-all termed "other." The bacteriology tests are broken into agglutinations, smears, cultures and "other"; this last division includes antibiotic sensitivities and antibiotic concentrations. Serology contains flocculations, complement fixations, and "other"; parasitology consists of feces studies, blood parasites, and "other."

The pathology section of the consolidated monthly report has nine subheadings; these are surgical specimens (gross), frozen sections, blocks made, slides cut (surgical), autopsy specimens, autopsy blocks, slides stained, animal autopsies, and "other." Under toxicology but one space is provided to enumerate all tests pertaining to toxicology; these include tests for heavy metals, alkaloids, barbiturates, alcohol, and so on. The ninth division is a general category "other." In this last division are placed all tests not properly classifiable into the previous eight divisions.

Now the question arises as to what constitutes a single test or examination. It may be simpler to point out what procedures are not counted as tests. These are: organoleptic inspections such as appearance, color and odor; sharpening of needles; washing glassware; preparing reagents and standards; sterilizing media; pouring of the culture plates; tubing of media; injecting of mice or rabbits; additional or repeat examinations on the same specimen to verify the accuracy of the original test; frozen sections; slides made or blocks cut in histology. Drawing of blood from donors is not counted although the original typing, serology, bilirubin and group determinations on the donor blood are counted.



Graph 1: The five major divisions of the SLMH are graphed for comparison. Each one of these divisions can be subdivided by further study as needed.

Almost all singly requested laboratory examinations are counted as one test when performed. Examples are blood sugar, urea, calcium, uric acid, phosphotase, and so on. Tests involving several specimens, such as urea clearance, glucose or galactose tolerances, count as one test only. Examinations in doublet, as cholesterol and cholesterol esters and albumin-globulin ratios, count as two tests for each doublet. A routine urinalysis is counted as one test and consists of color, reaction, gravity, albumin, sugar and microscopic study.

Concentration and dilution tests, phenolsulphonthalein excretion, glucose tolerance and galactose tolerance each count as one test, regardless of the number of specimens analyzed. The same holds true for gastric analysis, with one test credit regardless of number of specimens. Red blood cell count, white blood cell count, differential, hemoglobin, hematocrit, platelet count, sedimentation rate, bleeding time, coagulation time, clot retraction and sickle cell study each count as one test. Blood typing and grouping, although done in duplicate, each list as one test only, as does cross matching. A bacterial culture is considered as a single examination regardless of the number of organisms isolated, amount of culture media used, or serological reactions tried in identifying the organisms.

The coagulase test, bile solubilities, and similar tests are not counted at all. Smears which are done routinely on every culture and each drug used in antibiotic sensitivities are recorded as one test. In parasitology studies for malaria, ova and parasites and occult blood each count as one test. Under pathology, surgical, autopsy and "other" are counted as one each, although the specimen may consist of numerous pieces of tissue and many slides and blocks are prepared. Water, food and milk are counted on the specimen basis only. In serology each specimen counts as a single determination. The preparation and standardization of the reagents, furnishing sup-

plies to other hospital laboratories, the bleeding of sheep, and so on are not counted as tests.

Depending upon the use of the data collected, various members of the laboratory staff are included or excluded in the studies. In work load output and test per man-hour determinations, only those staff members whose daily work is listed on the tally sheets are counted. Examples of staff personnel certainly essential for the proper functioning of the laboratory but whose daily activity does not directly affect work loads are the pathologists, resident physicians, secretarial staff, morgue attendants, animal caretakers, dishwashers and probably administrative personnel. These are not included in work load output studies.

Conversely, in calculating test costs, preparing budget estimates, costs of laboratory service per patient day and similar studies, all assigned and part-time personnel, teaching members, consultants and other paid employes are included because their salaries are as much a part of laboratory expenses as are supplies, equipment and maintenance.

Using the criteria mentioned, namely, what constitutes a single test and which employes are counted, the monthly total of tests performed in a section is divided by the number of worker hours spent doing those tests. The resulting figure represents the tests per man-hour (TMH) for that department. Some accuracy is sacrificed by this method for the sake of practicability and expediency.

In a large hospital laboratory with men on duty 24 hours a day on a rotating shift basis, it is possible that a technician specialized in one field often does work in one or more of the other fields. A short review of this situation in our laboratory revealed that about 3 per cent of all chemical tests are done on shifts other than the regular day shifts, and that less than 0.5 per cent are done on the 24 hours of Sundays. The time spent in determining these minor factors appears not to justify the results.

Table 2—Over-All Laboratory Averages

Year	Avg. TMH
1952	5.3
1953	5.6
1954	5.4
1955	5.6
1956	5.9

The findings of operation studies, to be of value, must present consistent results, and any variations should be of minor significance. The system has been used now for five years and during this time approximately 4 million laboratory examinations have been performed. The over-all laboratory averages are shown in Table 2.

The tests per man-hour, by specialty or section, are shown in Table 3. Urinalysis is a subsection of the chemistry section. The figure of 6.5 TMH includes chemistry and urinalysis. The figure for urinalysis alone is 16.1 TMH compared to 4.5 for chemistry alone. Similarly, the blood transfusion section, the blood donor section, and hematology are grouped to give an average TMH of 7.4 while histology, serology and bacteriology are shown as separate sections.

In November 1956, there was an acute shortage of technologists. This required more than the usual amount of overtime. Ordinarily, overtime as used on occasion is not a significant factor in our work load studies, and it is therefore not calculated. To see what effect this might have on our findings, the November 1956 values are included in Table 3. The value of 9.2 TMH for hematology is highly undesirable because we have found that insufficient time can be spent with each specimen at this rate of work. There are also employe attitude and morale factors to consider when heavy loads are long continued.

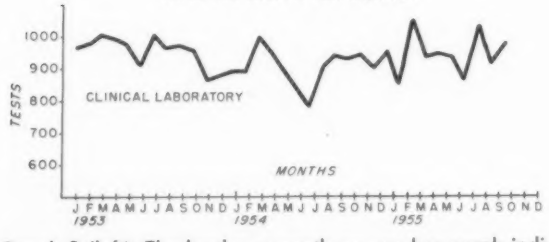
In checking for seasonal and monthly variations, we prepared Graphs 2 and 3. The load per month per worker varies with the length of the month and the number of holidays in the month, but aside from the usual variations in test distribution, nothing much of value in predicting work load output is gained. It is interesting to note that the monthly work load per worker varies from 800 to more than 1000 tests per month. Not all laboratories will reach such limits, while others, owing to test type distribution, may exceed these values.

Graph 3, showing work load per man-hour by months over a three-year period, shows that generally the work load or TMH varies from five to six. The drop shown in the summer of 1954 was caused by an adjustment in patient admissions, the parallel decreased load imposed on the laboratory, and a subsequent staff adjustment in laboratory force to compensate for the new situation. (*Cont. on p.* 108)

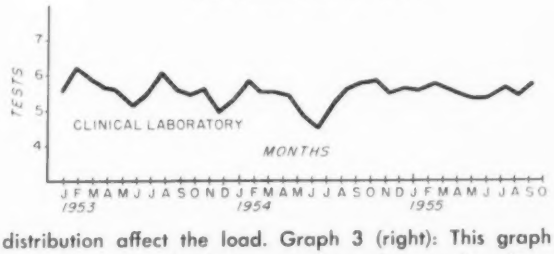
Table 3—Tests per Man-Hour by Specialty or Section

Specialty	TMH—1954	TMH—Nov. 1956
Bacteriology	3.8	4.0
Chemistry and urines	6.5	7.0
Hematology—transfusions	7.4	9.2
Histology	1.6	1.5
Parasitology	4.9	4.9
Serology	5.5	5.6
Average	5.4	5.9

GRAPH 2—
LOAD PER MONTH PER WORKER



GRAPH 3—
WORK LOAD PER MAN HOUR



Graph 2 (left): The load per month per worker graph indicates that work load varies from 8000 to just over 1000 tests per month per worker. Work days per month and test distribution affect the load. Graph 3 (right): This graph illustrating work load per man-hour, by months, shows that the average hourly test output varies from 4.3 to 6.31.

Many other guiding charts are utilized in management. In general, these tend to show that larger hospital laboratories have a lower cost per test, generally a greater number of tests produced per worker, and usually more tests per patient treated. These findings apply in particular to general medical and surgical hospital laboratories. In our large general, medical and surgical hospital, the following distribution of tests is characteristic: hematology, 43 per cent of the total test load; biochemistry, 28 per cent; bacteriology, 17 per cent; histology, 3 per cent; serology, 5 per cent; parasitology, 3 per cent; other, about 1 per cent.

The over-all laboratory hourly tests output remains within exceedingly close limits over a five-year period. The test load output per man-hour in each specialty also remains reasonably constant. The most important factors affecting test load output per hour appear to be work loads imposed, staff size variations, and the distribution of tests. The work load per man-month varies from 800 to slightly more than 1000 tests.

To be comparable, operations analyses of work done in clinical laboratories must be based on a standard test list and a strict interpretation of what constitutes a single test. One method of counting tests is presented. A review of the report forms and methods of test enumeration are discussed. The total laboratory staff is included in budgetary and cost analyses. Only those workers directly conducting tests are included in work output studies, while all workers in each section or specialty are considered in standard hour determinations.

The five activity divisions of the standard laboratory hour (SLMH) vary with each specialty, but each division in a specialty is consistent over an extended period of time. Likewise the average SLMH of all laboratory activities, when properly weighted for the number of technologists in each specialty, remains fairly constant. A review of the graphs and tables shows no direct relationship between the SLMH in a specialty and the test load output or tests performed per man-hour in that specialty.

A variety of factors undoubtedly influences the test output of clinical laboratories, and some of these are given. It is believed that the work production values as discussed will be characteristic for each laboratory. Comparisons may be made between laboratories serving similar types of hospital when hospital size and the matter of desirable service coverage are allowed for.

It is possible to apply management principles to hospital laboratories and to utilize the results in staff adjustments, grade assignments, budgetary matters, and other ways. The standard laboratory hour for separate large sections has been broken down into five components. For the entire laboratory these components average 37.5 minutes for benchwork; 6.4 minutes for specimen collection time; 6.8 minutes for rest and personal needs; 3.0 minutes for nontechnical duties, and 6.3 minutes for reagent preparation and cleanup.

A method for counting diagnostic laboratory examinations has been given and a study of test output per man-hour in each specialty has been presented. The average number of tests per man-hour for the entire laboratory in 1954 was 5.4; over a five-year period this value ranged from 5.4 to 5.9 tests. No correlation could be established between standard laboratory hour and test output per man-hour.

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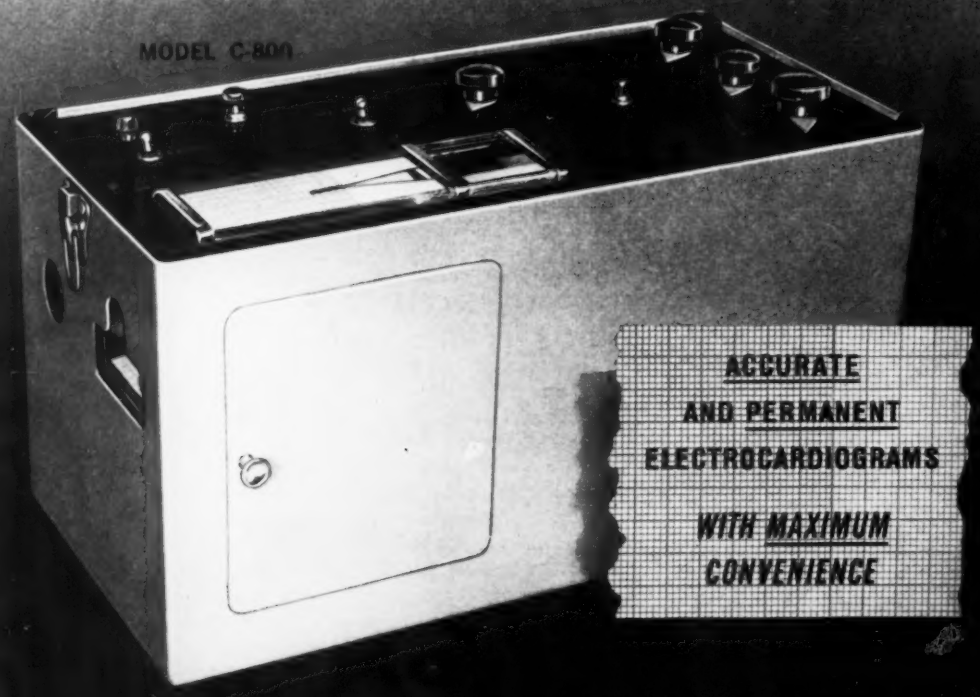

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The Toxicology of Metals

Review of the sources, manifestations and methods of treatment of metal poisoning

TOXICOLOGY may be defined as that phase of pharmacology dealing with the harmful effects of drugs used accidentally, homicidally or suicidally. The metals have occupied a prominent position among such agents since at least the time of the ancient Egyptians, who were acquainted with the toxic properties of lead, antimony and copper. Poisoning has not, fortunately, reattained the level of an art as it was practiced during the era of the Borgia family and the Machiavellian rulers, when the life of the lowliest or most exalted person could be had for a suitable price. Then, as now, favorite agents were arsenic and mercuric chloride.

Whatever the cause or motive, metal poisoning continues to be a not infrequent occurrence, and the chief sources, manifestations, and treatment of such poisoning should be known to each physician.

LEAD

Lead poisoning, or plumbism, is by far the commonest of the metallic poisonings, and its incidence is probably even greater than published reports indicate.

Some of the industrial sources of plumbism are: ore processing; manufacture of paints, storage batteries, caskets, automobile bodies, and plumbing equipment; rubber vulcanization; pottery glazing; processes using tetraethyl lead (absorbed through the skin); painting; soldering, and printing.

Sources of nonindustrial poisoning are quite varied. Pica is often a cause, in that children may gnaw upon objects covered with lead-containing paint. The fumes produced by burning storage battery casings are highly toxic, and these casings are often used as fuel by people in the lower economic strata. Poisoning has occurred from lead bullets embedded in the body for several years. It has also been caused by drinking water stored in lead pipes, using snuff wrapped in lead foil, and eating fruits and vegetables sprayed with lead arsenate. It is obvious that a high index of suspicion and a thorough history are essential to the detection of plumbism, as in the diagnosis of any metal intoxication.

Clinical manifestations of acute poisoning may include a metallic taste in the mouth, a dry or burning sensation in the throat, cramps, vomiting, bloody or black diarrhea, numbness, oliguria and convulsions. Death may occur on the third or fourth day in severe cases. Chronic poisoning may be manifested by weight loss, anorexia (especially at breakfast), fatigue, metallic taste, malaise, pasty complexion, colicky abdominal pains, vomiting, either diarrhea or constipation, and headache.

Peripheral neuritis frequently occurs, as indicated by joint pain, paresthesias, tremors and extensor paralysis in most-used muscle groups (typically, wrist-drop in painters and printers, shoulder and arm weakness in laborers, and leg weakness in children). Optic neuritis and atrophy are also seen. Lead encephalitis, productive of high mortality and seen most frequently in children, is associated with headache, tremor, insomnia, irritability, loss of memory, and, rarely, frank psychosis and convulsions. The often mentioned lead of Burton's line is a stippled precipitation of black lead sulfide at the gingival margin. However, a similar line may be found with bismuth or copper poisoning. In children, roentgenograms may aid in the diagnosis by revealing deposition of abnormally dense bone at the growing ends of long bones and along the margins of flat bones.

Laboratory Findings. The laboratory has assumed increasing importance in the diagnosis of lead intoxication. Erythrocytes may show basophilic stippling (Grawitz's granules), but this is by no means pathognomonic. Reticulocytes may be increased, and a low-grade secondary anemia is often found. Serum lead in excess of 0.03-0.07 mg/100 ml. is indicative of plumbism, as are urine levels greater than 0.08 mg/l. The most nearly pathognomonic test is the detection of coproporphyrinuria. Coproporphyrins I and III may be excreted in amounts ranging from 500 to 3000 micrograms per day, as compared to normal amounts of 100 to 300 micrograms per day. This excessive excretion is apparently the result of blockage of heme synthesis.

Treatment. The first principle of treatment is removal of the patient from the source of lead. Acute poisoning may be treated by gastric lavage and oral magnesium sulfate to form insoluble lead sulfate. Tincture of belladonna and morphine are valuable,

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Standard vs Disposable Unit Enema: Rainier, W. G. and Lee, B., Hospitals, 31:50, January 1, 1957.

(1) Swinton, N.W., Surg. Clin. No. Am., 35:833, 1955

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and calcium gluconate and ACTH or cortisone may also aid in the relief of abdominal colic.

EDTA (ethylenediamine tetra-acetic acid; Versene), a chelating agent, is the treatment of choice in plumbism. Its action lies in its ability to form an inner ring structure with a metallic ion, thus inactivating it. It is administered preferably as the calcium complex (monocalcium-disodium EDTA) to prevent chelating of serum calcium and subsequent effects of hypocalcemia.

The recommended dosage of EDTA is 50 mg./kg. per day, given five days in succession, followed by a two-day rest period. A total of three or four courses is usually given. A suitable schedule is to administer half the 24 hour dose at 12 hour intervals in 25 to 300 ml. of 5 to 10 per cent glucose solution intravenously, allowing approximately an hour for the infusion of each dose. Although the substance possesses definite nephrotoxic potentiality, severe renal tubular damage can probably be averted by administering EDTA in courses and by carefully following the patient with daily urinalyses.

Because lead may remain stored in the skeleton of children for a year or more, such patients should be observed for indications of recurrent intoxication caused by the release of stored lead. Such a release can be precipitated by illness and other factors.

ARSENIC

Arsenic is another extremely common metallic poison. Arsenic trioxide, which is tasteless, has enjoyed centuries of popularity as a suicidal and homicidal agent. This compound is fatal if taken in amounts of 130 to 200 mg. The real wonder is that arsenic poisoning does not occur more frequently than it does, considering its presence in such widely available and frequently encountered substances as insecticides, vermin killers, paint pigments, wallpaper, cloth, paper goods, and printers' ink. The recent and widely publicized accidental poisoning of Clare Booth Luce by paint flaking from a ceiling stands as a good example of the frequently bizarre causes of arsenic intoxication. Industrially, toxic amounts may be encountered in ore processing, in the manufacture of the many arsenic compounds and arsenic-containing products, and particularly when arsine contaminates the air.

In pre-penicillin times, when the trivalent organic arsenicals were used widely in the treatment of syphilis, poisoning from the medicinal use of arsenic was frequent. Trivalent and pentavalent forms are extensively employed at the present in some areas in the treatment of trypanosomiasis. Occasional instances of intoxication arise from the use of the very poisonous inorganic arsenicals in psoriasis and bronchial asthma. Acute arsenic poisoning may be manifested by either cerebrospinal or gastrointestinal syndromes. Signs and symptoms of acute cerebrospinal form include vertigo, headache, sensory disturbances, spasms of the musculature of the extremities, delirium, paralysis, profound circulatory collapse, convulsions and death in less than 24 hours. The acute gastrointestinal form may be manifested by the following: burning throat, esophagus, and abdomen; nausea and vomiting, often bloody; "rice-water" diarrhea; intense thirst; oliguria, with hematuria and/or albuminuria; clammy, pale skin; feeble pulse; collapse and death.

General manifestations of the chronic form may include general malaise, faintness, anorexia, abdominal pain, weight loss, and diarrhea or constipation. Skin changes may be prominent, including pale, waxy complexion, unusual callouses, bronze or coppery skin pigmentation, and eruptions or exfoliative dermatitis. Nails may be brittle, and white bands across them indicate periods of arrested growth. Peripheral neuritis is frequently present, with paresthesias, paralysis and muscle atrophy. Other effects may include agranulocytosis, nephrosis and hepatic damage. Death is commonly due to cardiac weakness as a result of fatty degeneration of the myocardium. Examinations of arsenic in hair, nails and other tissues can be determined in the laboratory with relative ease.

Treatment. Immediate treatment of poisoning by ingested arsenic consists of gastric lavage with a sodium thiosulfate solution, and saline cathartics. Morphine may be used to alleviate pain. The most effective therapeutic agent in both acute and chronic toxicity is BAL (British anti-Lewisite, Dimercaprol). BAL exerts its effect by forming a stable complex with the metal, thereby preventing or reversing the enzyme inactivation produced by combination of the metal with free sulfhydryl groups. The usual dose of BAL in peanut oil, administered intramuscularly, is 1.0 ml. of a 10 per cent solution per 50 pounds of body weight, given every four hours for from four to 10 days. Careful observation for toxic effects of BAL should be maintained. These effects include lacrimation, a burning sensation of the lips, dryness of the mouth, muscular aching, restlessness, paresthesias, sweating, pain, vomiting, apprehension, rapid pulse, and elevated blood pressure.

MERCURY

Industrially, toxic exposure to mercury has been reported in industries involving mining and extraction of the metal, amalgamation, felt processing, and manufacture of such articles as thermometers, barometers and mercury switches. Intoxication has occurred in laboratory workers exposed to mercury. Care should be exercised to prevent the escape of mercury into cracks and crevices in the laboratory, as large amounts of mercury can accumulate in this manner. Mercury compounds are used in a wide variety of medicinals, including germicides, cathartics, teething powders containing calomel, antisyphilitics, diuretics, abortifacients and vaginal douches, any of which can cause poisoning.

Corrosive sublimate (mercuric chloride) is often ingested with suicidal intent, and the toxic dose is only 200 mg. Death is usually prevented if vomiting occurs within 15 minutes of ingestion. However, the organic compounds of mercury are considerably less toxic.

Acute mercury poisoning is manifested by a metallic taste, constriction of the gastrointestinal tract with irritation and pain, vomiting, bloody stools, irregular pulse and respiration, coma and death. If death does not occur immediately, delayed mortality may result from renal tubular necrosis with subsequent uremia.

Chronic intoxication may present itself with anorexia, nausea, vomiting, diarrhea or constipation, excessive salivation, stomatitis, loosening of teeth, sore and bleeding gums, anemia, peripheral neuritis, loss of memory, irritability and excitability, intestinal ulcers, and renal damage. Hypersensitivity reaction such as skin lesions and acrodynia in infants are sometimes seen when mercurial medicinals are the offending agents.

Treatment. Treatment of the acute phase consists of administration of egg white and milk, or charcoal in water, followed by gastric lavage with 5 per cent sodium formaldehyde sulfoxylate

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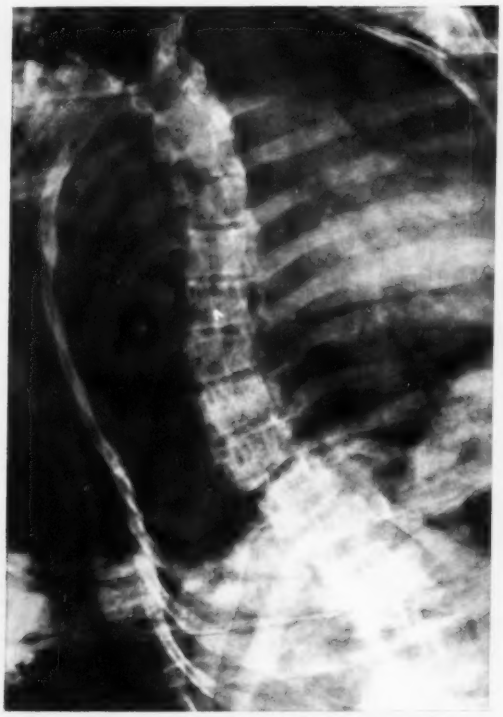
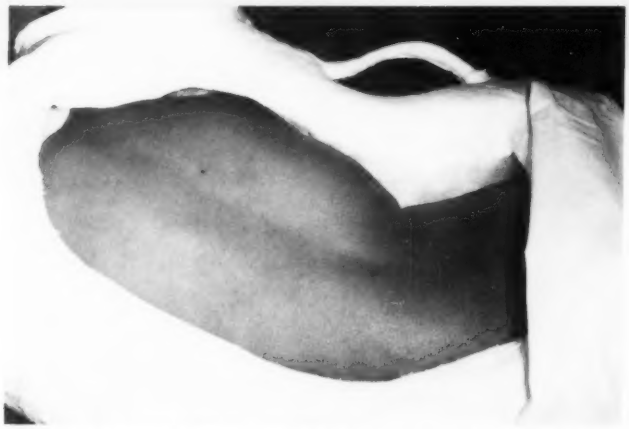
1. CASE: 14-year-old girl with idiopathic scoliosis. Precorrection radiograph with patient seated.



2. Postcorrection radiograph with patient in plaster jacket following spinal fusion (top and bottom of the fusion marked by metallic clips).



3. Right dorsal curve has been corrected in plaster turnbuckle jacket and back is seen exposed through window. Methylene blue tattoo marks identify area of vertebral column to be fused. *Steps in surgery shown on page following.*

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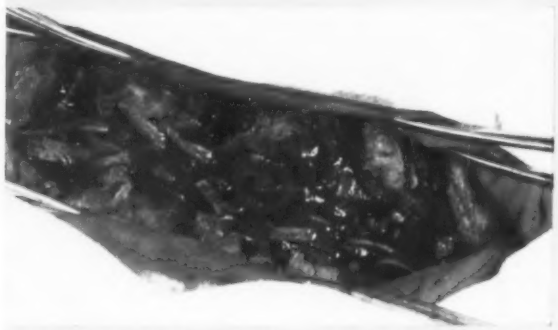
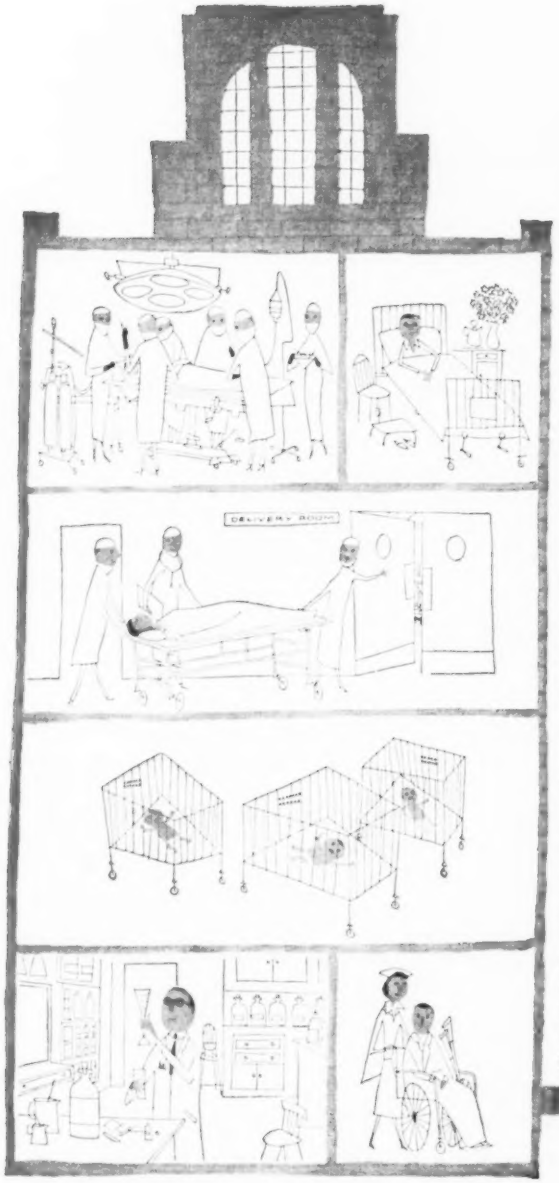
4. Posterior elements of the vertebrae to be fused have been exposed by subperiosteal dissection.



5. Interdigitation of bony spicules across the interlaminal spaces has been completed.

6. Raw bony area is reinforced by slivers of cancellous bone obtained from the bone bank.

7. Incision closed.



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solution. BAL is administered, as in arsenic poisoning, as soon as possible and is continued for at least three or four days. Survivals with BAL therapy after ingestion of as much as 2 gms. of mercuric chloride have been reported. This is also the treatment of choice in the chronic form. Morphine may be valuable for the alleviation of pain. Many patients may survive the oliguric, anuric and diuretic phases of tubular necrosis if careful attention is paid to electrolyte and acid-base balance.

BISMUTH

This is another therapeutic metal largely outmoded by antibiotics. Widely used in the past in the treatment of syphilis, bismuth deposits at the sites of injections can often be seen in x-rays of patients so treated. It is employed orally as a sedative in gastric irritation, but little is absorbed. The chief source of intoxication now is bismuth applied in pastes and salves to open wounds and burns.

Signs and symptoms of poisoning are: metallic taste; excessive salivation; foul breath; a black line on the gingival margins, similar to the so-called lead line; stomatitis; diarrhea with dark stools; albuminuria, occasional jaundice; dermatitis; pigmentation of soft palate and inner surfaces of cheeks.

Treatment is rarely necessary. BAL may be of some value.

ANTIMONY

A metal similar to arsenic, this is used medicinally as an emetic and antiprotozoal drug, in certain art work, in rubber vulcanization, and in storage battery manufacture. Antimony poisoning often occurs simultaneously with lead and arsenic poisoning because of their frequent close association in industrial situations, making differential diagnosis extremely difficult.

Manifestations of acute poisoning are severe gastrointestinal irritation with uncontrollable vomiting and diarrhea, corrosion of mucous membranes, a metallic taste, a sense of constriction in the throat, excessive salivation, rapid and weak pulse, weak respirations, convulsions, and death. In the chronic form, joint and muscle pain, acute arthritis, marked bradycardia, EKG changes, hepatitis, pneumonitis and loss of libido are prominent.

Therapy of acute poisoning caused by ingestion of antimony is gastric lavage with a warm solution of tannic acid. BAL is of doubtful value.

THALLIUM

The chief sources of thallium intoxication presently are rat poisons and depilatories. The metal enjoyed brief popularity in the treatment of ringworm of the scalp in children, but was soon found to be too toxic. It is, indeed, a most unnecessary and dangerous drug. Thallium poisoning should be suspected in every case of unexplained polyneuritis.

Toxic effects include lassitude, pain in the lower limbs, emesis, abdominal pain, albuminuria, central nervous system disorders, loss of hair (damage to endocrine organs, liver and kidney), disturbances of calcium metabolism, and polyneuritis. Death may occur.

Treatment with intravenous sodium thiosulfate gives indifferent results. The efficacy of BAL is dubious.

GOLD

Gold sodium thiosulfate and thiomalate have found use in the symptomatic treatment of rheumatoid arthritis and nondisseminated lupus erythematosis, and are usually given in weekly doses intramuscularly over a definite period of time.

Lesions of the skin and mucous membranes, including erythema, exfoliative dermatitis, stomatitis, gastritis, colitis and vaginitis, are prominent in gold poisoning, as are blood dyscrasias, renal damage, encephalitis, peripheral neuritis and hepatitis, urticaria, eczema, and colitis.

BAL is of definite effectiveness in the treatment of gold poisoning, and is administered as recommended for mercury and arsenic poisoning. ACTH is also apparently of some value in this condition.

SILVER

Silver poisoning can result from either industrial exposure or incautious use of silver-containing medicinals. Silver salts have long been employed in medicines and cosmetics, and the incidence of argyria has varied in direct proportion to the popularity of silver compounds in therapeutics. Silver nitrate has been a frequent offender, as has silver in organic combination with protein in such preparations as argyrol and protargol.

A burning sensation in the gastrointestinal tract, vomiting, vertigo, paresis, collapse, and death are typical events in the acute form of silver intoxication. The chronic form is ar-

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gyria, in which the ingested silver is distributed mainly in the skin, producing a characteristic bluish pigmentation which may be mistaken for the cyanosis of heart disease. A slate-blue silver line at the gingival margin may be the first indication. The famous "blue man" of the Barnum and Bailey circus was a victim of argyria.

Acute silver poisoning may be treated by precipitating insoluble silver chloride by the administration of sodium chloride and demulcents. The cosmetic disfigurement of argyria is its only ill effect, but this is almost impossible to remove. Some success has been reported with multiple intradermal injections of 10 per cent potassium ferricyanide with 6 per cent sodium thiosulfate solution. BAL is ineffective in argyria.

CADMIUM

Cadmium used in the plating and glass industries is occasionally involved in poisoning. Cadmium-plated pots, trays and pitchers containing acid foodstuffs and beverages have caused several poisonings, and the incidence of nonfatal cadmium food poisoning is probably much higher than published reports indicate.

In acute intoxication caused by cadmium ingestion, prominent findings are a violent gastritis accompanied by nausea, cramps, vomiting, diarrhea, weakness, and a metallic taste. If the metal is inhaled, symptoms such as dryness of the throat, cough, headache, vomiting and a sensation of precordial constriction are present. Severe dyspnea and prostration may follow. Cadmium may be detected in the urine, and is good evidence of cadmium absorption, but the amount found is not related to the severity of the intoxication.

Strikingly variable chronic syndromes have been reported in workers in battery factories. Manifestations are: pains in the lumbar region and lower limbs, and gait disturbance; milkman's syndrome with pseudofractures—invisible to x-ray, and a golden-yellow discoloration of the dental cement caused by cadmium sulfide. Emphysema and arremia are frequently present. A proteinuria of low molecular weight, different from that seen in glomerulonephritis, cardiovascular-renal disease, or multiple myeloma (Bone-Jones protein), is also seen. Emphysema and/or the proteinuria may be found in any one patient.

BAL has been utilized in the treatment of systemic intoxication, in that it causes severe renal damage by deposition of cadmium.

SELENIUM

Marco Polo in 1295 A.D. probably first described selenium poisoning when he observed that a plant in the mountains of Eastern Turkestan caused the hoofs of animals to drop off. "Alkali disease" and "blind staggers" are the animal forms of selenium intoxication, seen after the ingestion of vegetation containing high concentrations of the metal.

The chronic forms of selenium poisoning are seen in men living in seleniferous regions. There people show high urine selenium concentrations, gastrointestinal disturbances, hepatic enlargement, dermatitis, and arthritic symptoms. Industrial selenosis is seen in the copper, steel, ceramic, photographic, rubber and photoelectric apparatus industries. A typical picture of poisoning would include gastrointestinal disturbances, erythema, pallor, dermatitis, acute nasal and respiratory irritation, dizziness, a garlicky odor of the breath and a metallic

taste. Selenium poisoning may also be caused by misuse of selenium sulfide suspensions, available for the treatment of dandruff.

BAL will reduce liver damage due to selenium, but will, as in cadmium poisoning, increase renal damage. Vitamin C may remove the breath odor. Sodium arsenite and arsenate decrease toxicity in livestock. Bromobenzene is said to increase the rate of selenium excretion in laboratory animals, but no human trials have been reported.

BERYLLIUM

Beryllium intoxication is usually found in the metal, ceramic and fluorescent lamp industries, and more recently those occupations involving atomic energy technology. This is an insidious disease, typically having a period of clinical latency following the last exposure. The characteristic pulmonary granulomatosis may be apparent on x-ray films years before the onset of symptoms of pulmonary insufficiency, which include cough, fatigue and progressive dyspnea and cyanosis. Furthermore, the similarity of the roentgenogram to the patterns seen in sarcoid, silicosis and tuberculosis makes diagnosis of berylliosis difficult. Other manifestations include contact dermatitis, ulcerations and granulomas of the skin; conjunctival inflammation and corneal ulceration are also found.

Treatment of the skin lesions consists of curretage of ulcers and surgical removal of granulomas. ACTH and cortisone produce subjective and objective improvement in pulmonary function, without obvious change in the x-ray picture. However, progression to a more fibrotic state appears to be arrested.

MANGANESE

In 1837 the first case of chronic manganese poisoning was reported. The patient was a workman who crushed the metal. The primary sources of the disease continue to be limited to the mining of the metal and the basic chemical industries. Acute manganese intoxication is rare. The chronic CNS form often simulates hepatolenticular degeneration (Wilson's disease), with mask-like facies, languor, intention tremor, muscle pain, spastic gait, emotional disturbances, and, occasionally, cirrhosis of the liver. A chronic manganese pneumonitis also occurs. The effects of exposure to manganese are cumulative and appear only after several months' exposure. The victims are life-long cripples if seriously poisoned.

Treatment is only symptomatic. The course of the disease is progressive and unalterable, but usually nonfatal.

BARIUM

Although the insoluble barium sulfate used in roentgenology and as an antidiarrheal and demulcent powder is nontoxic, soluble barium salts are sometimes administered by mistake. This is almost the sole source of barium poisoning at the present, since barium chloride is no longer used in the treatment of heartblock.

Toxic doses produce generalized smooth muscle stimulation, reflected in vomiting, diarrhea, hypertension, myocardial stimulation, and skeletal muscle tremors. Hemorrhage and central nervous system paralysis may be present. Inhalation of barium produces an asymptomatic pneumoconiosis.

Treatment consists of immediate administration of sodium or magnesium sulfates by mouth to precipitate the barium as the sulfate and to promote elimination. Intravenous calcium or magnesium salts will antagonize the muscular stimulant effects.

VANADIUM

Intoxication by this metal is found in some metal and mining industries.

The most prominent manifestations are: inflammation of eyes and respiratory tract, continuous coughing and wheezing, profuse expectoration, dyspnea, chest pain, emphysema and green-black discoloration of the tongue. The most constant biochemical finding is a depression of fingernail cystine content to an extent of 19 per cent or more below normal levels. However, a similar depression occurs in some patients with chronic arthritis of 10 years' or more duration, cirrhosis and certain types of cancer.

BAL is ineffective; treatment is purely symptomatic.

TELLURIUM

The metal, glass and rubber industries provide most of the cases of tellurium poisoning. Signs and symptoms are suppression of sweating, dryness of the mouth with a metallic taste, anorexia, vomiting, somnolence, dry and itching skin, and an unpleasant garlicky odor of the breath. Ascorbic acid is said to abate this odor, and BAL may be of some benefit in the treatment of the other symptoms.

(*Continued on Page* 120)

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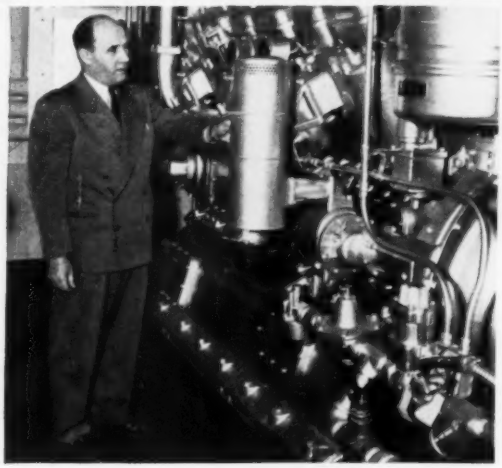

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QUARTER CENTURY OF DIESEL LEADERSHIP

(*Continued From Page* 118)

LITHIUM

Lithium salts enjoyed some popularity as a salt substitute for patients on a low-sodium diet until several deaths were reported from their use. This is a good example of the occasional poor experimental design of pharmacological testing methods, since no animal toxicity could be demonstrated in the usual preliminary experiments. However, animals on a low salt diet will show the same symptoms seen in patients on a low salt diet when lithium is given. The clinical course of intoxication includes anorexia, nausea, tremor, muscle twitches, apathy, blurring of vision, coma and death. The only known treatment is to increase salt intake and remove the source of lithium.

URANIUM

It is not within the scope of this paper to discuss radiation effects. In addition to such effects, however, uranium metal poisoning occurs and results from industrial uses of soluble compounds. The action is primarily a nephrotoxic one, with acute renal tubular necrosis following a latent period of up to four days after exposure. Victims either die or are completely recovered within a month. Treatment consists of large amounts of bicarbonate or citrate initially, followed by careful management of electrolyte and acid-base disturbances. BAL is dangerous, as it increases the nephrotoxic effects.

MISCELLANEOUS

Some other metals that are rarely of toxicological importance but that should be kept in mind are aluminum, tin, copper, iron, chromium, nickel, platinum, osmium, zinc and cobalt.

SUMMARY AND CONCLUSIONS

The principal sources, manifestations, and treatments of poisoning by commonly encountered metals are presented. A high index of suspicion is a primary prerequisite to the diagnosis of intoxication by these substances. The signs and symptoms outlined are by no means pathognomonic, and the laboratory and roentgenologist are rarely of great help. A careful, detailed history and, frequently, painstaking detective work remain as the most reliable aids to an accurate diagnosis and recognition of metal poisoning.—ROBERT B. SCOGGINS, B.S.

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Teaneck, N.J.

THANKS to quick freezing, ready-to-cook packs, highly organized distribution, and simplified portion control, shrimp is no longer restricted to the gourmet's menu. Shrimp has its place in the hospital menu, first, because it is a food that staff and patients enjoy. Moreover, shrimp is a source of important nutritional value. It is a relatively good source of complete protein and is low in fat. Shrimps rank next to oysters in mineral content and supply some vitamins.

Light to eat and easy to prepare, shrimps make ideal warm weather fare, but there's no season, really. Hot or cold, fried, sautéed, boiled, broiled, in casseroles or sandwiches, shrimp fits into menus for patients, staff and in the coffee shop.

Shrimp is available virtually everywhere in the United States. It will vary in color, depending on where it is caught. The generally recognized colors are white or greenish gray, brown or pink. Regardless of the color, fresh shrimps with the shells on and heads off are referred to as "green" shrimp.

Shrimps are never sold with the heads on; these are removed as soon as the catch is brought in. Then most shrimps are quick-frozen. Approximately 90 per cent of the total production is sold either iced or quick-frozen.

SIZES AND PACKS

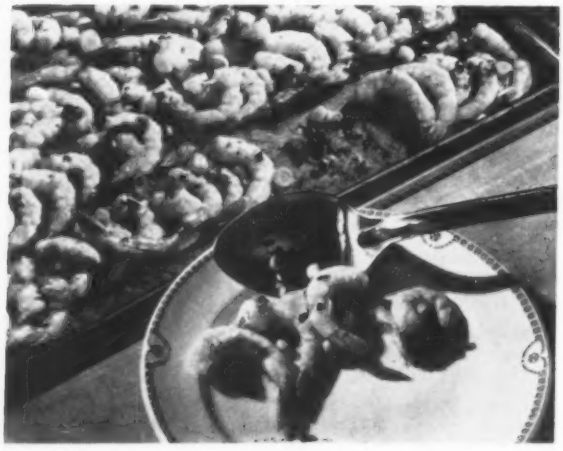
Shrimps with the heads removed are graded according to the following sizes: 15 or fewer per pound; 16 to 20 per pound; 21 to 25 per pound; 26 to 30 per pound; 31 to 42 per pound, and 42 or more per pound.

The dietitian has her choice of sizes which, in fresh shrimp, vary with the season. The largest are the most expensive, but from the point of view of labor, they are the most desirable, and so operators usually find them practical. The smaller shrimps, which usually are less expensive, have the same flavor and food value. These are economical where labor is available at off-hours, and in dishes where shrimp is used in combination with other foods.

Raw shrimps purchased fresh have the shells on. Frozen shrimps are packed raw with shells on; raw or precooked, peeled and deveined; raw, peeled, deveined and breaded. Most practical is the 3 pound institutional pack of frozen individually water-glazed shrimp. The cook does not need to use the whole package, but can take out only the amount needed.

The frozen ready-to-cook breaded shrimps come in two shapes: the "round" (unsplit) and "butterfly" (split). For these, the tails are left on but are uncoated for attractiveness in serving. The "butterfly" type look well and appear bigger on the plate, but the "round" type are said to have more flavor because they have less surface area to dissipate it. Much of the breading used on commercially breaded shrimp contains seasoning—salt, pepper, monosodium glutamate—that enhances shrimp flavor considerably. Where breading mixture contains only

(Continued on Page 126)



BROILED SHRIMP

Place shrimps in broiler pan or heatproof serving dish. Season with salt, pepper, monosodium glutamate. Brush with melted butter. Broil 3 inches below heat; turn once. For other recipes and pictures, see pg. 124.

SEAFOOD NEWBURG

DEVILED SHRIMP

Baked Seafood Newburg

Yield: 50 6-Ounce Portions

- 1 pound butter or fat
- 3 cups flour
- 1 gallon cream, light*
- 2 teaspoons salt
- ½ teaspoon pepper sauce
- 2 tablespoons Worcestershire sauce
- 6 No. 1½ cans shrimp
- 6 13-ounce cans tuna fish**
- 24 eggs, hard cooked
- 2 teaspoons monosodium glutamate

Make a sauce of the butter, flour, cream, and seasonings.

Combine shrimp with tuna broken in pieces and quartered eggs. Turn into baking pans or casseroles. Bake in a moderate oven (350° F.) about 30 minutes.

*Half cream and half milk may be used.
**Crabmeat or lobster may be used in this combination also.

Deviled Shrimp

Yield: 50 5-Ounce Portions Sauce on 6-Ounce Portions Rice

- 9½ quarts converted rice, cooked, hot
- 8 pounds shrimp, cooked (fresh or frozen)
- 1¼ cups each lemon juice and Worcestershire sauce
- 2 pounds onion, minced
- 1½ pounds butter or margarine
- 1 pound flour
- 5 quarts milk
- 3 tablespoons each curry powder, dry mustard, paprika
- ¼ cup salt
- 2 teaspoons pepper
- 2 teaspoons monosodium glutamate
- Dash of nutmeg
- 1 dozen egg yolks

Dice shrimp, reserving two whole for garnishing each serving. Marinate in lemon juice and Worcestershire sauce for an hour or longer. Cook onion until tender in melted butter or margarine and remove from heat. Remove onion from pan and blend flour with remaining fat. Add milk gradually and cook over low heat, stirring constantly, until sauce is thickened. Drain shrimp. Combine remaining lemon juice and Worcestershire sauce with egg yolks and remaining seasonings. Beat thoroughly. Stir into sauce. Add shrimp and cooked onion. Heat thoroughly and serve over hot cooked rice. Garnish each serving with parsley and 2 whole shrimp (dip tails in paprika for extra color).

Shrimp Salad

Yield: 25 2-Ounce Portions

- 6 pounds shrimp, peeled, deveined, frozen
- 1 quart celery, sliced thinly
- 1 small onion, grated
- ½ cup pickle relish
- 1 tablespoon salt
- ½ teaspoon white pepper
- 1 teaspoon monosodium glutamate
- 1½ cups mayonnaise

Prepare shrimp according to package directions; cool and cut coarsely.

Combine all ingredients, tossing lightly. For full flavor, allow to set in refrigerator about 15 minutes before serving.

Breading Mixture

For About 15 Pounds Fish Fillets; 50 to 60 Chops or Cutlets; 100 Croquettes

- 2 pounds packaged bread crumbs
- 1 large onion, grated
- 2 tablespoons salt
- 1 teaspoon pepper
- 2 tablespoons monosodium glutamate

Combine all ingredients; mix thoroughly. To save time, prepare dry mix in quantity in advance and add onion when using.

If monosodium glutamate is used directly on the meat or fish before breading, then reduce monosodium glutamate in the breading mix by two-thirds.

Since many commercially prepared breading mixtures contain salt, pepper and monosodium glutamate, taste tests will determine how much additional monosodium glutamate should be used for maximum flavor.

Tomatoes Stuffed With Shrimp

Yield: 50 Servings of 1 Tomato, ⅔ Cup of Stuffing

- 15 pounds shrimp, fresh or frozen*
- 3 gallons water
- 1½ cups salt
- 50 tomatoes, large
- 2 quarts rice, cooked
- 2 pounds cheese, grated
- 1½ cups eggs, beaten
- 3 tablespoons salt
- 2 teaspoons monosodium glutamate
- 1½ teaspoons pepper sauce, if desired
- 2 cups dry bread crumbs
- ½ cup butter, or other fat, melted

Wash shrimp, place in boiling salted water. Cover and return to boiling point; simmer 5 minutes. Drain, peel and remove sand vein. Cut large shrimps in half. Wash tomatoes. Remove stem ends and centers. Place tomatoes in two well greased baking pans (14 by 19 by 1 inches). Combine rice, cheese, eggs, seasonings, and shrimps. Portion filling into tomatoes using a No. 6 scoop (⅔ cup). Top with crumbs which have been mixed with butter. Bake in a moderate oven, 350°F., for 30 to 35 minutes or until tomatoes are tender.

*Or use 7½ pounds peeled, deveined frozen or canned shrimp.

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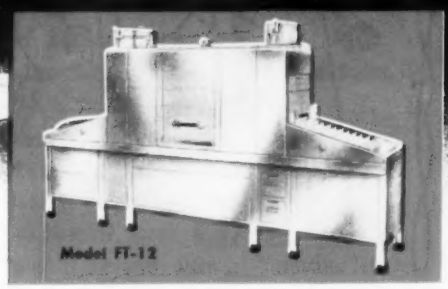
with a Hobart Flight-Type



You'll sparkle as your dishes and sanitary standards sparkle — *and sparklingest of all will be your cost-per-serving figures!*

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More—you can economically select a Hobart Flight-Type Dishwasher geared exactly to your volume requirements and available space. Model FT-12 fresh water scraps, power washes and rinses—all in 12 feet of space.

The Model FT-26 (illustrated) power scraps, power washes, power rinses and final rinses with additional time-for-drying. And between these two are many other models. Conveyor speeds can range from 5 to 12 ft. per minute.

If you have a smaller operation, there are many other Hobart automatic or semi-automatic models to choose from. Ask the advice of your local Hobart dealer. But if you're medium-sized and busy—or big—be sure to see the *Hobart Flight-Type*—the *only* dishwasher built with all stainless steel Flight-Type conveyors. A less expensive conveyor with nylon flight links is available. **The Hobart Manufacturing Co., Troy, Ohio.**

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a minimum of the glutamate, the cook can add more monosodium glutamate for maximum flavor.

Canned shrimp comes in various sizes of both shrimp and can. It is best to check with the supplier as to can size, size of shrimp, and whether or not the shrimp are deveined.

New to the market is a dehydrated shrimp which comes vacuum packed in 26 ounce tins. According to the distributor, each can is equal to 7 pounds of fresh, raw headless shrimp. Each reconstituted shrimp is whole, deveined and cooked and suitable for immediate use in shrimp cocktail, breading and so on. Taste tests have pointed up the advantage of using 1 tablespoon of monosodium glutamate together with 2 tablespoons of salt to each gallon of water for reconstituting.

BUYING CONTROL

A word regarding portion control and how much to buy: One pound of fresh or frozen shrimp purchased with shells on will yield one-half pound cooked and peeled shrimp. One-half pound of cooked and peeled or canned shrimp should be used where recipes call for 1 pound of raw shrimp, fresh or frozen, according to the Shrimp Association of the Americas.

Portion control is "built in" in the frozen ready-to-cook product. The dietitian orders under 15 size, 16 to 20's, 21 to 25's or 26 to 30's, for example, according to her budget and menu needs, and knows what portions will result.

Frozen ready-to-cook shrimps, generally, should not be defrosted before cooking. Where frozen water-glazed shrimps are used in a recipe such as curry, it may be necessary to wash off the glaze under warm water lest too much melted ice spoil the recipe.

To boil: Place frozen shrimps in boiling seasoned water. (For each gallon of water use 4 tablespoons salt, 1 tablespoon monosodium glutamate and the juice of 1 lemon.) Let water return to a boil, then immediately remove from heat. Let shrimps cool in the cooking water. Drain.

To fry: Place shrimps in fry basket so that they are separated. Do not overload basket. Fry in good quality deep fat or oil at about 350° F. for two to three minutes, or according to directions on the package. Drain well. Sprinkle with monosodium glutamate at serving time for top flavor.

To shell fresh or frozen raw shrimp: Fresh or frozen shrimps may be peeled and cleaned either before or after boiling. To clean, hold tail end in left hand, slip thumb under shell between feelers, and lift off two or three segments in one motion. Then, still holding firmly to tail, pull out shrimp from remaining shell section. For "butterfly" style fried shrimp, leave the tail on. With a knife, cut along outside curvature and lift out all the black sand vein. The vein is harmless but considered undesirable by most people who like shrimp. There are several inexpensive gadgets available which are said to speed up shelling and deveining by hand considerably.

To boil fresh raw shrimp: Place shrimps in boiling seasoned water. When water returns to boiling, turn heat low so that water just simmers. Cover and let cook three to five minutes, not longer. Drain. As a measuring stick the Shrimp Association of the Americas gives these figures: Use 3 gallons of water to 15 pounds of shrimp with shell on. Net yield of shelled shrimp will be about 7⅛ pounds E.P.

To prepare "butterfly" shrimp, using fresh or frozen raw shrimp. Peel

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the shrimps and cut through the center, splitting in two sections, almost to the tail. Wash out the sand vein, dry the shrimps and flatten them out. Dip in a mixture of beaten eggs and milk in the proportion of 6 eggs to 1 cup of milk. Drain and roll in bread or cracker crumbs which are seasoned with 1 tablespoon each of salt and monosodium glutamate per pound of crumbs. Hold for frying in single layers on wire racks.

If a heavier coating and slower browning are desired, the salted shrimps may be first rolled in crumbs, then dipped in the egg and milk mixture, and finally rolled in crumbs again.

An alternate to the simple crumb dip is the unusually tasty and versatile breading mixture described earlier.

The topic of frying shrimp—or anything else that is breaded—would be incomplete without a word about commercial breading mixes, several of which give excellent results with considerably reduced labor. Usually, it is necessary only to moisten the shrimps and roll them in the mix, and they are ready for instant frying.

MORE SHRIMP DISHES

Shrimp cocktail, salad and Creole style always "go." So do fried shrimp. But in the busy hospital nutrition department other shrimp dishes should not be overlooked. Hearty shrimp bisque is suitable as the main dish for the light meal of the day and on some restricted diets. Three or four fried shrimps on a toasted bun spread with cocktail sauce or tartare sauce sells well over the cafeteria counter. Croquettes make shrimps go farther and yet "sell" the croquettes. Shrimp sauce enhances boiled or baked fish and fish croquettes.

DO'S AND DON'TS FOR SHRIMP

Don't defrost, then refreeze.

Do refrigerate at 40° F. or lower; freeze at 0° F. or lower.

Don't overcook; simmer, never boil.

Do bring out full flavor by using monosodium glutamate in cooking and for overcoming "steam table fatigue."

Do cook as near as possible to serving time.

Do fry in relatively small quantities in clean fat.

Do prepare and freeze shrimp croquettes, casseroles and so on during slack time to reduce eventual rush.

Do take time with sauces; cream, cocktail and tartare sauces should enhance, not overwhelm, the shrimp.

MAIN KITCHEN—

16-slice Powermatic toaster makes up to 1200 slices per hour! Model 4-1D5-D shown, $556.00†

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4-slice Powermatic toaster makes up to 300 slices per hour! Model 1D5 shown, $134.50†

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Most important, the Toastmaster Powermatic Toaster makes *perfect* toast every time. The exclusive Superflex Timer—the most accurate ever developed—gives every slice the same uniform goodness. It even compensates for normal voltage fluctuations. The no-levers-to-press feature is important too, for saving time and labor, wear and tear. There's no lost motion—no banging to cause needless wear.

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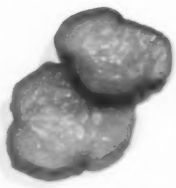
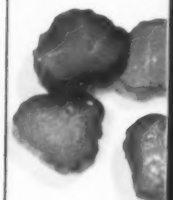
CHOOSE YOUR TEST SAMPLE FROM TODAY'S NINE TOP-SELLING HEINZ PICKLES

For the last five years, Heinz sales figures have shown a definite change in people's pickle tastes. People are buying more and more of the milder dills and sweet pickles. Here are the top nine . . . take your choice to make your taste test.



Heinz Fresh Cucumber Pickle—so mild, crisp and fresh.

Heinz Sweet Gherkins and Sweet Midgets have a crunchy crispness.



Heinz Sweet Cross-
a spicy sweet liq

Heinz Sweet Relish—adds zip to bland flavors.

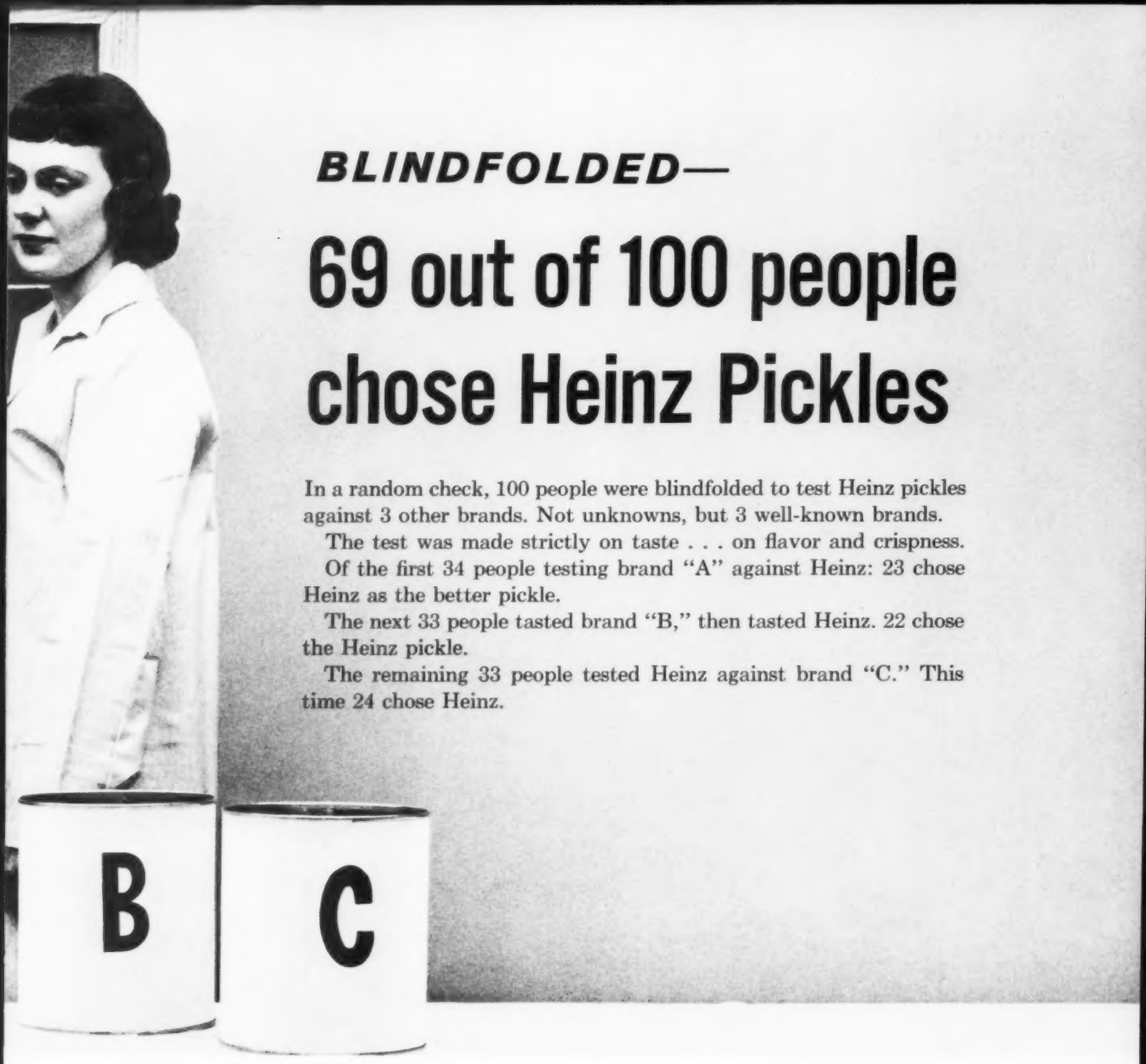
Heinz Whole Kosher Dills—perfectly shaped with uniform flavor.

Heinz Hamburger Relish—spicy tomato base.

Heinz Cross-Cut Kosher Dills . . . just enough true garlic tang.

Heinz Hamburger Slices—sharp, spicy chips, light on garlic.

Heinz Hot Dog Re
with a sharp mustar



BLINDFOLDED—

69 out of 100 people chose Heinz Pickles

In a random check, 100 people were blindfolded to test Heinz pickles against 3 other brands. Not unknowns, but 3 well-known brands.

The test was made strictly on taste . . . on flavor and crispness.

Of the first 34 people testing brand "A" against Heinz: 23 chose Heinz as the better pickle.

The next 33 people tasted brand "B," then tasted Heinz. 22 chose the Heinz pickle.

The remaining 33 people tested Heinz against brand "C." This time 24 chose Heinz.

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We'll bring the pickle variety you choose. Then compare Heinz with your present brand of pickles.

You'll agree that nobody makes pickles like Heinz. We use our own pedigreed strain of cucumbers. They have thin, tender skins . . . crispy little seeds. They're painstakingly cleaned, then cured the long, old-fashioned way according to original Heinz pickling recipes. Nothing but Heinz own fine vinegars and choice spices and herbs are used. Heinz pickles are crisp from the centers out . . . they hold their natural green color. They are vacuum packed in space saving #10 tins to insure Heinz quality.

Nobody makes pickles like HEINZ

Heinz 57 Pickles

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H. J. Heinz Company
Hotel & Restaurant Division
Box 28, D-7, Pittsburgh 30, Pa.

Let me see for myself. Tell your representative to come—prepared to make the blindfold test.

_____
(choose any of the pickles shown)

Name_____ Position_____

Restaurant or Company_____

Street_____

City_____ Zone____ State____

Menus for July 1957

Patricia Ritter
Dietitian
Santa Ana Community Hospital
Santa Ana, Calif.

1
Orange Juice
Scrambled Eggs
•
Roast Veal
Currant Jelly
Mashed Potatoes
Green Beans
Vanilla Custard
•
Beef Barley Soup
Macaroni and Cheese
Stewed Tomatoes With
Toast Cubes
Ginger Pear Salad
Lemon Pie

2
Apple Juice
French Toast, Bacon
•
Roast Leg of Lamb
Mint Jelly
Parsley Buttered
Potatoes
Buttered Beets
Ice Cream With
Fresh Strawberries
•
Cream of Pea Soup
Meat Pie, Vegetables
Tossed Salad With
Russian Dressing
Fruit Cup

3
Fresh Figs
Soft Cooked Egg
•
Roast Beef
Mashed Potatoes, Gravy
Glazed Carrots
Parker House Roll
Bread Pudding
•
Cream of Celery Soup
Asparagus Rolled in Ham
With Cheese Sauce
Pear, Cottage Cheese
Salad
Boston Cream Cake With
Whipped Cream

4
Pineapple Juice
Poached Egg
•
Turkey Tetrazzini
With Noodles
Green Beans
Biscuits
Fresh Orange Dessert
•
Beef Noodle Soup
Breaded Veal Cutlet
Spinach With Lemon
Stuffed Prune,
Apricot Salad
Butterscotch Pie
With Whipped Cream

5
Cantaloupe Half
Scrambled Eggs
•
Fried Halibut, Lemon
au Gratin Potatoes
Harvard Beets
Cornbread
Strawberry Shortcake
•
Tomato Soup
Salmon Loaf With Egg
Sauce
Buttered Peas
Pineapple, Grated Cheese
Salad
Jelly Roll

6
Apricot Nectar
Soft Cooked Egg
•
Swiss Steak
Mashed Potatoes
Summer Squash
Fresh Peach
•
Vegetable Soup
Spanish Rice
Tossed Salad
French Bread
Cocoanut Pie

7
Grapefruit Juice
Poached Egg, Roll
•
Fried Chicken, Gravy
Mashed Potatoes
Peas and Carrots
Lettuce, 1000 Island
Dressing
Ice Cream,
Butterscotch Sauce
•
Scotch Broth
Cheese Soufflé
Buttered Asparagus
Applesauce in Lime
Gelatin Salad
Lazy Daisy Cake

8
Stewed Prunes
Scrambled Eggs
•
Broiled Liver and
Bacon
Parsley Buttered
Potatoes
Corn on the Cob
Bavarian Cream
•
Chicken Broth
Broiled Cube Steak
Buttered Lima Beans
Sunshine Salad
Canned Pear,
Filled Cooky

9
Vegetable Juice
Soft Cooked Egg
•
Meat Loaf
Hawaiian Baked Potato
Wax Beans
Watermelon Slice
•
Chicken à la Reine Soup
Veal Cutlet, Wisconsin
Style
Spinach With Lemon
Stuffed Celery and Olives
Strawberry Chiffon Pie

10
Pineapple Juice
Poached Egg
•
Hungarian Goulash
Oven Browned Potatoes
Buttered Carrots
Caramel Custard
•
Potato Soup
Creamed Chicken on
Toast
Buttered Peas
Tomato Aspic Salad
Cherry Pie

11
Baked Apple
Scrambled Eggs
•
Roast Veal
Currant Jelly
Buttered Rice
Buttered Lima Beans
Canned Peach,
Chocolate Chip Cooky
•
Split Pea Soup
Spaghetti With Meat
Sauce
Tossed Salad With
French Dressing
Hard Roll
Sherbet

12
Cantaloupe Half
Soft Cooked Egg
•
Baked Salmon Steak,
Lemon
Mashed Potatoes
Green Beans
Cornbread
Tapioca Pudding
•
Clam Chowder
Creamed Tuna and Noodles
Buttered Zucchini
Spring Salad
White Cake, Chocolate
Icing

13
Orange Juice
French Toast, Bacon
•
Lamb Chop
Creamed Diced Potatoes
Succotash
Apple Snow
•
Consommé
Stuffed Bell Pepper
Buttered Carrots
Macaroni Salad
Pumpkin Pie With
Whipped Cream

14
Tomato Juice
Blueberry Muffins
•
Prime Rib
Mashed Potatoes
Buttered Peas
Cheese Biscuit
Ice Cream, Chocolate
Sauce
•
Beef Barley Soup
Welsh Rabbit on
Toast Points
Buttered Green Beans
Fresh Fruit Salad
Chocolate Cake, White
Icing

15
Grapefruit Juice
Scrambled Eggs
•
Ham Loaf
Escalloped Potatoes
Buttered Spinach, Egg
Slice
Apricot Cobbler
•
Vegetable Soup
Beef Pattie
Summer Squash
Fruit Gelatin Salad
Pineapple Cheesecake

16
Stewed Prunes
Poached Egg
•
Swiss Steak
Parsley Buttered
Potatoes
Buttered Carrots
Gingerbread, Whipped
Cream
•
Cream of Potato Soup
Veal Parmigiana
Buttered Asparagus
Blushing Pear Salad
Fresh Cherries,
Snickerdoodle Cooky

17
Tomato Juice
French Toast, Bacon
•
Roast Turkey
Dressing, Gravy
Cranberry Sauce
Buttered Lima Beans
Chocolate Pie
•
Cream of Celery Soup
Broiled Lamb Pattie
in Bacon Ring
Julienne Beets
Fresh Fruit Salad
Cupcake, Chocolate
Icing

18
Cantaloupe Half
Soft Cooked Egg
•
Roast Beef
Escalloped Potatoes
Wax Beans
Ice Cream
•
Tomato Soup
Chicken Fricassee on
Biscuit
Peas and Carrots
Sliced Cucumber Salad
Pineapple Pie

19
Orange Juice
Scrambled Eggs
•
Fried Halibut,
Tartare Sauce
Parsley Buttered
Potatoes
Buttered Zucchini
Cornbread
Watermelon Slice
•
Cream of Mushroom Soup
Spaghetti, Tomato and
Cheese Sauce
Cooked Vegetable Salad
Sunshine Cake

20
Apple Juice
Poached Egg
•
Southern Style Meat Loaf
Baked Potato
Spinach With Lemon
Sponge Cake
•
Chicken à la Reine Soup
Meat Pie, Vegetables
Sliced Tomato Salad
Purple Plums, Cooky

21
Pineapple Juice
Coffee Cake
•
Fried Chicken, Gravy
Mashed Potatoes
Mixed Vegetables
Tea Rolls
Ice Cream, Pineapple
Sauce
•
Scotch Broth
Cheese Stratta
Buttered Asparagus
Orange, Cocoanut Salad
Jelly Roll

22
Vegetable Juice
French Toast, Bacon
•
Roast Lamb
Mint Jelly
Parsley Buttered
Potatoes
Glazed Carrots
Floating Island
•
Chicken Rice Soup
Cheeseburger
Green Beans
Tossed Salad, French
Dressing
Orange Fruit Cake

23
Prune Juice
Soft Cooked Egg
•
Baked Ham
Candied Yams
Buttered Peas
Parker House Roll
Boysenberry Cobbler
•
Oyster Stew
Club Sandwich
Potato Chips
Pickles, Olives
Fruit Cider Salad
Lemon Cake Pudding

24
Sliced Oranges
Cinnamon Roll
•
Roast Veal
Currant Jelly
Mashed Potatoes
Spinach With Lemon
Red Cherry Cottage
Pudding
•
Tomato Soup
Macaroni and Cheese
Harvard Beets
Ginger Pear Salad
Caramel Brownie

25
Pineapple Juice
Scrambled Eggs
•
Meat Loaf
Hawaiian Baked Potato
Wax Beans
Ice Cream
•
Consommé
Baked Chicken and
Noodles
Buttered Zucchini
Apple Medley Salad
Cherry Pie

26
Grapefruit Juice
Soft Cooked Egg
•
Baked Salmon
Parsley Buttered
Potatoes
Corn on the Cob
Banana Cream Pie
•
Vegetable Soup
Shrimp Wiggle
Buttered Carrots
Grape Salad
Layer Cake, Apricot
Filling

27
Apple Juice
Scrambled Eggs
•
Beef Stew, Vegetables
With Noodles
Cheese Biscuit
Cocoanut Custard
•
Beef Noodle Soup
Escalloped Potatoes
and Ham
Green Beans
Sliced Tomato Salad
Pear Crisp

28
Cantaloupe Half
Poached Egg
•
Prime Rib
Mashed Potatoes
Summer Squash
Lettuce Wedge,
Russian Dressing
Tea Roll
Ice Cream With Fresh
Sliced Peach
•
Split Pea Soup
Cottage Cheese Salad
Ribbon Sandwich
Potato Salad,
Apple Frost Pie

29
Orange Juice
Soft Cooked Egg
•
Lamb Curry, Rice
Buttered Carrots
Banana in Lemon
Gelatin, Whipped
Cream
•
Cream of Celery Soup
Broiled Canadian
Bacon
Green Beans
Deviled Egg Salad
Cream Puff

30
Stewed Prunes
French Toast, Bacon
•
Roast Turkey
Dressing, Gravy
Cranberry Sauce
Buttered Peas
Watermelon Slice
•
Scotch Broth
Veal Croquette
Spinach With Lemon
Tossed Salad, 1000
Island Dressing
Fresh Strawberries
Snickerdoodle Cooky

31 Tomato Juice, Coffee Cake • Minute Steak, Baked Potato, Buttered Beets, Cherry Glazed Pie • French Onion Soup, Spanish Liver, Corn on the Cob, French Bread, Sliced Cucumber Salad, Sherbet

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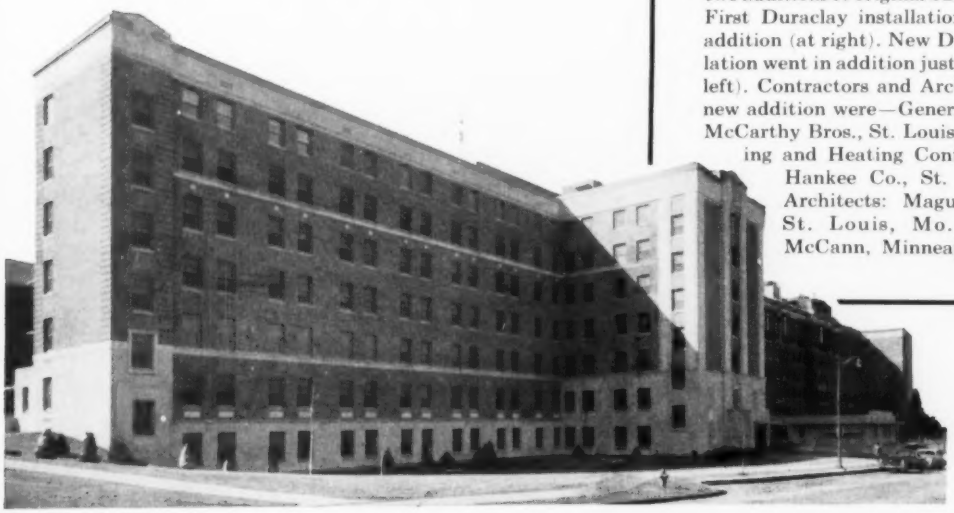

St. Mary's Hospital, serving the Mayo Clinic, Rochester, Minnesota. Crane Duraclay fixtures were selected for the two additions to original building (center). First Duraclay installation was in 1939 addition (at right). New Duraclay installation went in addition just completed (at left). Contractors and Architects for the new addition were—General Contractor: McCarthy Bros., St. Louis, Mo.; Plumbing and Heating Contractor: W. J. Hankee Co., St. Paul, Minn.; Architects: Maguolo & Quick, St. Louis, Mo., and R. V. McCann, Minneapolis, Minn.

REFLECTIONS ON HOSPITAL LIGHTING

5. Dining Areas, Auditoriums, Chapels, Classrooms

HOWARD HAYNES and K. A. STALEY

THE contemporary decorator who studies preliminary sketches of hospital lunch bars, dining rooms, and cafeterias usually has in mind a freer approach to the general style of treatment. These areas today call for less dignified, somewhat gayer, solutions so the lighting can be less conventional.

Continuing the series on hospital lighting. The authors are application engineers in General Electric's Nela Park lamp and lighting headquarters in East Cleveland. They have been gathering the material for the last three years. The MODERN HOSPITAL is presenting the articles serially as reference aids to the hospital architect, designer, consulting engineer, administrator or departmental executive who is planning new space or the relighting and redecorating of existing space.

DINING AREAS

Whether the approach is expressed in more colorful draperies, brighter furniture coverings, uninhibited murals, or bas-relief in contemporary styling, the lighting can augment all of these. Lighting can add sparkle and zest to a room simply, often inexpensively, and always subtly.

One wall, for example, might be moderately floodlighted by a row of downlights or a long troffer luminaire. A flower group in a floral niche or on a low table could be highlighted. A fireplace with a mirror above the mantel could have lighting concealed in the top and sides. An island showcase could add a respectable touch of color in an unexpected manner with tinted lamps, or there could be back-counter decorations, made luminous by a concealed cove above them.

Good classroom lighting aids teacher and nurses. These fluorescent lamps show colors in balance, important to lessons where skin tone is vital.

Tinted lamps in pale shades of blue, green, gold and pink are designed for unusual use, not for locations where critical or prolonged difficult seeing tasks are performed. They serve to create mood in the relaxed living areas, those having a residential character, where decorative treatment and "atmospheric" qualities are emphasized. Three types of lamps can be used to supply tinted light. The most recent line of tinted bulbs is conventionally shaped in 75 watt, 100 watt, and 150 watt sizes, and in 50-150 three-light lamps. With one tint called dawn pink, the warm color tints, reds to pinks, such as natural flesh tones, are visually accented. To produce a cool tone in a room, or part of a room, the blue-white lamp, called sky blue would be a good choice. Rooms done in cool tints of light (as they do also under north sky light) seem larger, cooler, and quieter, but do not necessarily lack verve or sparkle, other things being equal.

Such tinted bulbs are used principally in portable lamps, in certain downlights, and in built-in panels, boxes or niches. For lighting devices in which reflector or projector lamps are commonly employed, tinted lamps also are available in both types. The tints are somewhat different, and these in turn differ also from the tinted (and pure

Simple lines of surface mounted luminaire make it inconspicuous. Fluorescent lamps provide good color on foods.

Accent lighting emphasizes merchandise of this attractive hospital gift shop, which opens off an inside corridor.

Good stage lighting adds a professional touch. Circuits are on dimmer control; storage space is below the stage.

Valances in the chapel are fitted with 40 watt fluorescent lamps; recessed spots are 150 watt filament lamps

color) fluorescent lamps—pink, blue-white, gold, red and green. Since the effects also are evident on furniture, fabrics and room accessories, some preliminary testing might be in order so that the results will be in keeping with the decorative theme.

The color lamp affects complexions least of all. The sky blue lamp produces the most vibrantly alive appearance, owing to heightened skin tones, principally. It also emphasizes the blueness of blue eyes, warms highlights in hair, and retains makeup coloring. The sun gold lamp (pale yellow) produces a warm ruddy look, owing to "golden" highlighting — a sunset coloring.

The staff dining areas are important. The staff needs a relaxing atmosphere at mealtime. At least, such an atmosphere helps in the day's work to give a certain relaxation of spirit. Lighting and decoration done properly can do much to create such an atmosphere. On the other hand, dining areas are often lighted by crystal fixtures or other simulated chandeliers of early times and the effect is far from pleasant. Their bare bulbs, simulating candles, are glaring and poor imitations of the candle's traditional soft, pleasant lighting. Such bulbs should be shaded.

In all rooms with more modern lighting in which food is served, it is necessary to pay attention to the color of "white" fluorescent lamps that are installed. In the rush of opening, an uninformed service man could (and often does) install the wrong color lamps.

AUDITORIUMS AND CHAPELS

A modern auditorium is a distinct asset in hospital communication. It can serve for general group assembly and also for religious gatherings for staff and patient groups. A circular sacristy for Catholic, Protestant and Jewish services in a Cleveland hospital for chronic invalids is illustrated. There are few pews; space is allowed principally for wheel chairs. It is a space saving plan of considerable merit. Lighting for the preacher is by downlights just ahead of the front pew. The general lighting in the nave is on dimmer control for movies and lectures.

The size of an auditorium should be limited to specific seeing and hearing limits. Seeing limits are somewhat fixed by the critical angle of detail which an individual can detect. It is about one minute of arc. Thus a quarter inch of movement of eyes or lips represents one minute of visual angle at 75 feet. The measurements are rough, but this appears to be about the reasonable limit of depth of auditorium seating. Shorter distances, of

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YOU CAN DEPEND ON DOW

Good lighting eases strain of those learning new skills, but even these departments often are poorly illuminated.

Five parabolic lamps are on each pole. Fluorescent street lighting luminaires also can solve this lighting problem.

course, produce greater visual comfort. The limiting width of lecture rooms is indicated by surveys showing that people will not voluntarily choose seats farther to the side than 100 degrees from the face of the stage or platform opening. The width is also restricted by the seeing angle for viewing motion pictures and slides. This limits the audience to a 30 degree arc from the center line of a mat screen and to 22 degrees from the center line of a beaded screen. Outside these zones the screen brightness drops off markedly. The posture of persons in fixed seats at a considerable angle from straight-on viewing of a screen or a speaker is usually uncomfortable. If possible, rows of seats should be placed in arcs, not in straight lines.

A combination chapel-auditorium is a good compromise solution where dual-purpose rooms present a closer approach to a minimum of capital cost. The program requirements in the average hospital should present no conflicts.

Flat floors and movable seating are often desirable for practical reasons. Where dancing is a part of the patient and staff entertainment schedule, this type obviously is necessary.

General lighting creating suitable brightness patterns gives the effect of a well lighted, pleasant room. A lighting level of not less than 10 footcandles is necessary. This permits easy seeing for seating, note taking on tablet-armchairs in class, and similar relatively easy sight tasks. The readings are generally taken on a horizontal plane about 3 feet from the floor. A reading on a typical sloped reading-plane might represent a truer plane of seeing. Some authorities feel that the vertical and near-vertical planes are the most important in classroom or lecture interior space. The usual general lighting system will almost invariably produce in vertical planes about half of the footcandle level in horizontal planes.

STAGE LIGHTING

The requirements of stage lighting are varied, depending on the size of the hospital and the uses to which the stage is put. Most entertainments which are given on a stage deserve the extra emphasis afforded by controlled lighting. The added (vertical) illumination not only makes it easier to see the action on the stage but it also aids the performers psychologically.

Types of stage lighting equipment in the order of their importance are:

1. Ceiling spotlights. These are generally mounted on the auditorium ceiling. These spotlight the speaker at a rostrum on the stage apron and provide the necessary frontal light on speakers, singers or actors on the stage farther back.

One of the most effective ways of spotlighting stage action is with ellipsoidal reflector-lens spotlights, equipped with beam-shaping shutters. Beams can be adjusted to specific acting areas and stray light can be kept off the proscenium arch.

Spotlights are usually located so that their beams form a 45 degree angle when aimed at a person standing slightly behind the first border lights.

2. Border lights. These are mounted on the stage ceiling or "flown" from the ceiling of the loft in a high stage. Spotlights are placed at the first border. First and second borders, as illustrated, have three 6 foot striplights with twelve 150 watt lamps in each. Color circuits recommended are not the conventional red, white and blue, but medium amber, magenta and blue. The combination of the three produces white light.

3. Footlights. The best type for hospital stages are disappearing footlight strips, hinged, to be opened when needed. By this means a clear floor is possible at most times, which makes better use of the stage floor. For a 25 foot stage, five 5 foot sections are suggested with twelve 75 watt spotlights with three color circuits—pink, amber and light blue.

4. Cyclorama footlights and spotlights. These groups are used to light the backdrop and rear stage area. The overhead lighting may be of the border-strip type or large reflector floodlights can also be used. For outdoor sets, they are especially effective to brighten the "sky" area. Color is easily obtained by gelatin frames which snap onto the lamps or reflectors. Units should be placed about 10 feet forward from the surface to be lighted. Rough, sand-floated white cement plaster on the rear stage wall provides a reasonably good cyclorama. Theatrical scrim hung in front of the surface enhances the illusion of depth.

5. Portable equipment. A number of portable floodlights and spotlights are desirable in some hospital stages, although their number should be kept to a minimum. They can be mounted on pipe stands or fastened to the back of stage scenery. Their principal use is to light doorways, background scenery, and similar flats.

6. Control methods. Dimmer control of audience lighting is highly desirable as it eliminates the ocular shock of bright lights to dark-adapted eyes. Manual control of incandescent or fluorescent lamp circuits is a reasonable solution for single-point control. Motor control is, of course, more convenient on house lights when the control points may be both on stage and at the projection booth or near the projectionist when no booth is required.

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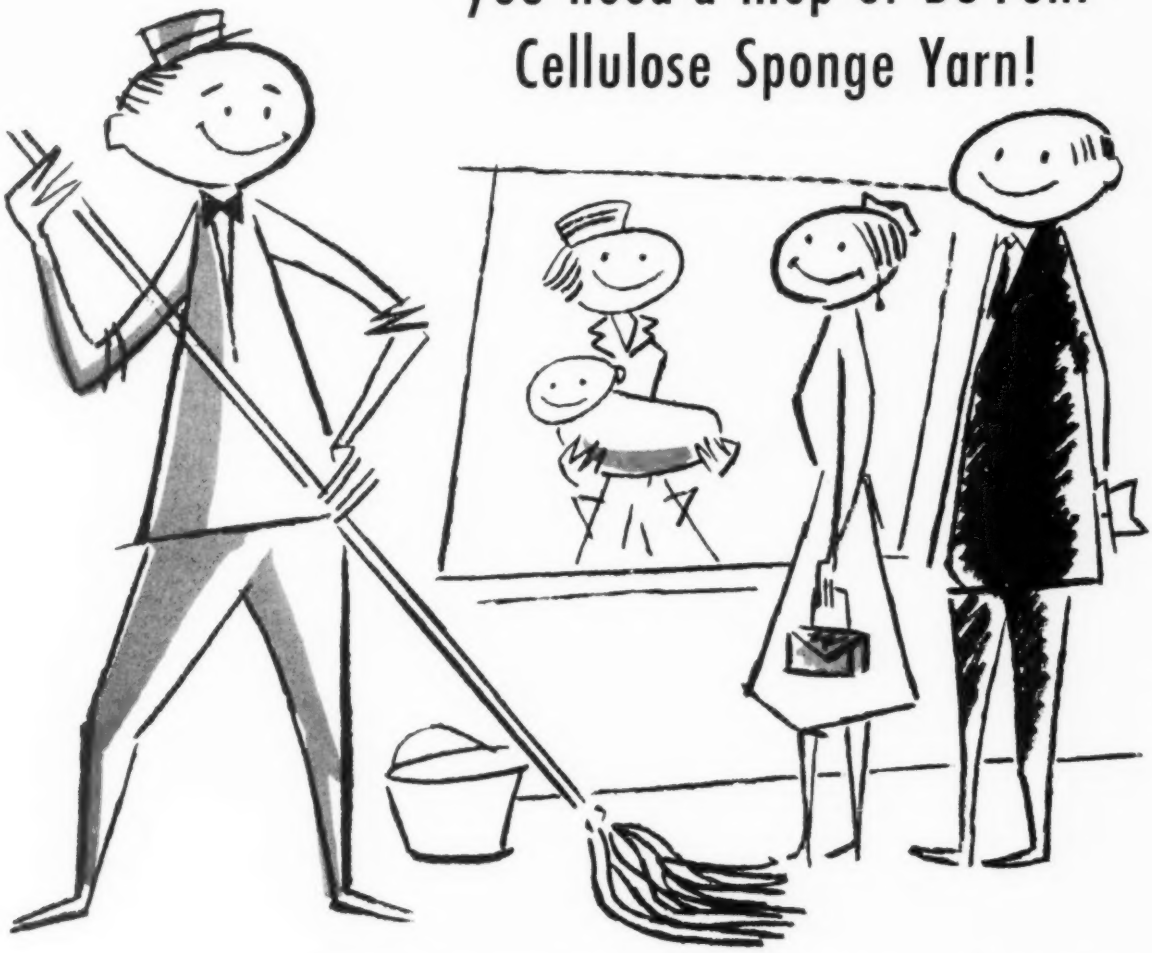

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(called the simplified method) was recently devised by a lighting engineer, Del Kershaw. In the usual small auditorium classroom, one circuit so controlled is often sufficient to give the illusion of general dimming. If the room is lighted with a fluorescent system, one or more circuits can be on dimmer control and used to bring the room up gradually from blackout. Other circuits can then be turned on to bring the general level up to full brilliance. The simplified circuit controls four, eight, 22 or 44 four-foot fluorescent lamps.

During a presentation where the lecturer uses a group of slides, has a break for discussion, and then shows slides again, a dimmer circuit is most convenient for supplying a reasonable amount of light after showing slides in relatively dark surroundings. Complete blackout is not desirable for most slide and movie showing. Also, at least one footcandle is needed on table arms for note taking.

CLASSROOMS AND SEMINARS

All teaching areas should be well lighted. A lecturer is handicapped unless he has satisfactory illumination, particularly on vertical surfaces such as chalkboards. Chalkboard lighting is relatively new; generations of students, particularly those in rear seats, have struggled under the handicap of not seeing the blackboard clearly. Chalkboard luminaires are now made by a number of firms that use both filament and fluorescent lamps. In the modern classroom, their inclusion is highly desirable.

A small seminar of the amphitheater type, which has a lighting system with sufficient variations in control to satisfy all requirements for lectures and demonstrations and the more special visual aids, is illustrated. These systems include general lighting, chalkboard lighting, and downlights on dimmers for slide and motion picture lectures. It should be emphasized that for note taking during a lecture, it is necessary to supply about one footcandle of illumination on the chair arms. A setting on the dimmer-control knob should be marked accordingly.

CHALKBOARD CHOICE

Green chalkboards have become increasingly popular. They are available in glass, plastic, steel and composition board construction. Green chalkboard paints are also available. Slate boards are still good writing surfaces and with the addition of trough or built-in lighting can be illumined to a brightness ratio of 3 to 1 with the surrounding wall surface. Green chalkboards, because of their high reflectance (15-20 per cent) meet this brightness-ratio requirement without additional lighting; however, increasing their brightness usually aids visibility. Any improvement is especially valuable for those in the back of the room.

WALL AND CEILING COLORS

The proper choice of wall and ceiling tones in classrooms not only improves the lighting in general, but it brings these areas in the field of view in brightness harmony with other objects that are seen in the room. Examples are books, instruments, objects being demonstrated or explained, notes, people's complexions, the face of the lecturer, and the skin tones and general appearance of the patient being studied.

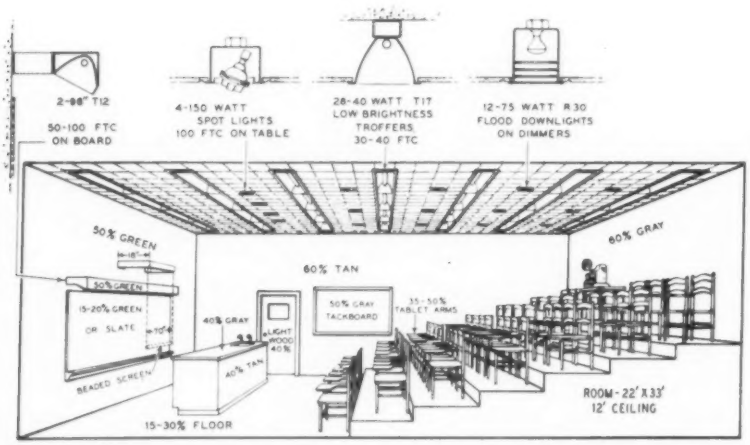
FURNITURE TOPS

Nearly all new desks and office furniture in general are obtainable in natural blond finishes which meet the 30-35 per cent reflectance prerequisite. Plastic replacement desk top (linoleum) materials of similar reflectance are also available; these are easily cemented to dark and work-worn surfaces. This procedure — resurfacing dark surfaces — is clearly necessary after a room has been redecorated in light tones.

OCCUPATIONAL THERAPY ROOMS

Occupational therapy rooms are small editions of industrial areas in a practical sense and in a seeing sense. As a result, the principles of good industrial lighting apply to them. In the space devoted to manual arts, such as woodworking, weaving, light metalworking, and general crafts, low-brightness sources with a good component of light toward the ceiling are a good answer. Standard types of industrial fixtures now have this desirable distribution of upward and downward light. As a rule, the spacing between fixtures should not exceed 1½ times the mounting height above the work (work to fixtures). This rule ensures reasonable uniformity over the work areas. When the general lighting system furnishes uniform lighting, the location of individual machines is immaterial, as far as seeing goes; patients can see relatively equally well in all parts of the room. Three to five lamp-watts per square foot is considered a desirable ratio.

A common error in small shops has to do with the relative position of machines and windows. If patients have to face bright windows, they cannot always see well. It is generally better to have the machines in such a position that the light comes from one side or the other, generally from the left side for right-handed persons. This is a simple enough principle, but it is violated in a surprising number of cases. Bench and desk types of work such as leathercraft, beadwork and simple weaving need strong local light



The amphitheater type of auditorium has an important place in communication, particularly for the hospital staff. Classes are well lighted and downlights give light on tablet-armchairs at a low level. (See text)

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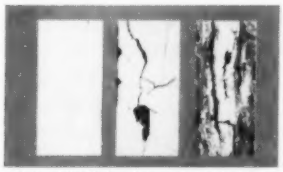

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where the details are fine. Here some sort of auxiliary light may be extremely worth while.

Effective local lighting can be had from fluorescent fixtures with single or double tubes in a small housing. These supply extra light where needed without the customary "hot spot," as from filament-lamps sources. Reflector or projector filament lamps mounted on the ceiling also can be combined in the same reflector body and the combination adds effective auxiliary light over machines such as drill presses, saws and similar power tools.

SEEING FOR THE AGED

The parameters of size and contrast, relating to the objects to be seen, are important in any seeing concept. They are particularly vital when the patient is old. To this end it would be preferable to have all reading matter in large type. But as a rule this is difficult or impossible, as current periodicals are commonly set in 8 point or 10 point type. Newsprint is inherently harder to read than a well printed book because of poor contrast between the printing and the necessarily cheap paper.

By the same reasoning, games and sports, especially table games, should be chosen for their large detail. A large television screen is preferable, for example. With table games, special attention should be paid to the reduction of reflected glare from glossy surfaces such as playing cards, word-game letters, and the like. One means of control in these visual elements is to supply light from large low-brightness surfaces. Using the ceiling as a secondary source, as in indirect lighting, is a good answer. Torchères or indirect luminaires are incandescent types of lighting that would be recommended for service of this kind.

ENTRANCE, MARQUEE, EMERGENCY

Requisites for good entrance lighting include quick identification of regular and emergency entrances. The main entrance requires at least one footcandle of general lighting over the roadways, under marquees, and on the walks from the parking area to the entrance doors. Parking areas are in much greater use than any others; they are never empty!

A relatively dignified appearance of the main building façade is desirable and higher brightness of the walls and roadway helps to indicate the nature of the entrance. Extra illumination helps ambulance drivers and doctors who enter this part of the building.

In many sections of the country, yellow lamps (filament and fluorescent) are recommended for principal and emergency entrance platforms during the warm months of the year. The insect (and spider) population near the fixtures is reduced thereby, resulting in less maintenance.

ROADWAY LIGHTING

Plans for drives, walks and parking areas on the hospital grounds should be carefully studied for night hazards as well as for daytime traffic needs. Nurses and other staff members must use these paths and roadways during early evening hours in the dark winter months; similarly, the early morning traffic is not inconsiderable. These hours of personal hazard deserve safety consideration.

Alleyways, walks, spaces between buildings, and particularly dark areas in which low overhanging foliage or shrubbery abounds should be scrutinized for shadows in which a predator might lurk. Forested roads and particularly the roads and walks to and from emergency entrances deserve excellent light coverage. (It is not sufficient just to have a lighted sign to illuminate this important space.)

One good general rule in spacing street luminaires is that they should be close enough so that if one lamp burns out anywhere along the line, light from the two adjacent luminaires could "fill in" the dark space, at least until a new lamp can be installed. Approximately a 2-to-1 spacing for general medium-spread types will satisfy this requirement.

Trees should be well pruned on hospital grounds, at least to the height of the lamps. Spacing luminaires along a roadway to accommodate existing trees is frequently desirable. The luminaire-spacing symmetry need not be changed significantly in most cases. A few extra poles may be needed to fill in between large trees. To get lamps over the road center, it may be necessary to increase the length of mast arms (as foliage thickens) or to use span-wires.

Fluorescent street lighting luminaires, which are large diffuse sources, have the advantage of wider spread of the light. Their modern appearance, greater visibility on wet pavements, and higher-efficiency lamps make them an excellent choice.

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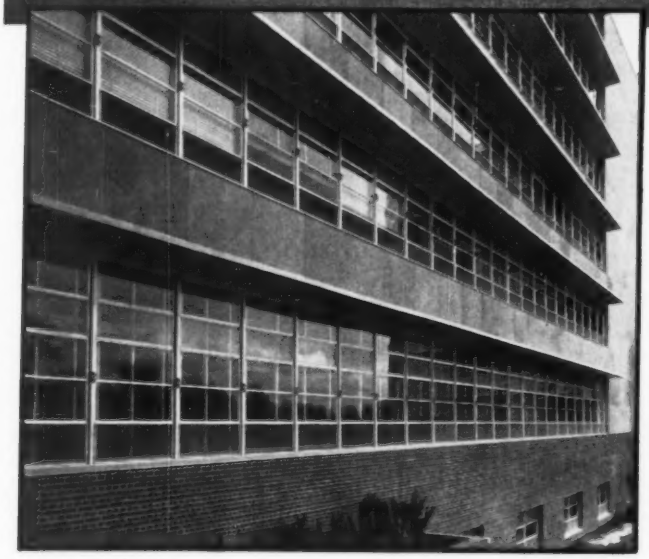

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BARBARA D. MILLS

This is the fourth lecture in the series given by Barbara Mills, director of housekeeping services, St. Luke's Hospital, Chicago, to her administrative housekeeping trainees. Because she is training them to be department heads, she constantly stresses the necessity for developing the qualities of leadership. This lecture concludes the section on scheduling the work load and also covers a "tour" of the hospital during which Mrs. Mills discusses the attitudes that the administrative housekeeper should adopt in her dealings with patients.—ED.

THESE past weeks you have acquired a good basic understanding of production standards, work flow and distribution of work load through the medium of schedules. You have substantially increased your knowledge of special words, their spelling and terminology as used in the hospital field, as well as those used in your training program. Your ability to classify objects correctly permits me to believe that the word "nomenclature" is no longer foreign to you. You have also learned that all work needs a definition.

To date all the areas given you to staff have been only large enough to require coverage in accordance with established production standards. Now we will add another word to your "preplanning" of functions. Up to this time all the preplanning has been done for you so our next step is for *you* to learn preplanning in order to organize the areas for staffing.

CREATIVE THINKING

This step will require extensive use of your imagination. Imagination is a leading factor of productivity. What does it take to bring this *latent* ability into being? I cannot say with definite assurance that there is nothing to it, for this will depend upon you and how well you can "play house" plus your ability to apply common sense.

I am sure you remember when you, as a youngster, organized the front porch, or perhaps your bedroom, into a four or five room home. You were "setting up housekeeping" and about to raise a family. Do you also recall how hurt you became when a member of the family failed to recognize the *chair as a stove* or when he entered your home and failed to *knock* or *open a door*—all of this was very real to you—in the theater of your mind.

Now some years later you are imagining this is your first charge as an administrative housekeeper and after a survey you have listed the areas for staffing as follows:

Lobby and offices
Lecture areas
Kitchen and dining areas
Basement—
  Central supply
  Lockers and bathrooms
  Housekeeping areas
X-ray department
Operating area
Staff quarters
Disposal
Stairs and elevators
Laboratory
Outpatient department
6 Patient floors
  1 Pediatrics
  1 Obstetrics

Note: There is no set time for guest to check out.

Your decision as to size of areas, type of coverage, implemented by our basic principles, will influence your organization and staffing. Probably no two of you will make schedules alike so don't let it worry you.

As we continue to practice staffing in its various forms let's break the monotony and visit some hospital areas to get a firsthand conception of who institutes these services we have been talking about—actually gets them done—and also become acquainted with our guests.

ATTITUDES AND BELIEFS

Generally speaking, if you follow instructions, there is nothing to harm you in the hospital. Therefore you have nothing to fear. True, some sights may not be too pleasant to witness; they may upset or excite you. Nevertheless, your horror or displeasure does not need to register in your expression. Hysteria or panic cannot play a part in your emotions for, as a

leader, it is your job to *strengthen others*. Apropos of this, I believe it pertinent at this time to touch upon some of the factors responsible for a seeming apprehension among you. During your orientation tour I heard such expressions as

"I hope I don't see any blood; it makes me very ill."

"I think I would faint if I saw anyone dead."

"Hope I don't have to work on maternity. Those delivery rooms must be horrible to clean up—all that blood and stuff."

"Please don't make me go near the operating rooms—the smells make me very ill."

These are all popular misconceptions and your presupposing what would happen was very interesting. At that particular time I quieted your fears by permitting you to "swing on the garden gate" but the time has arrived when we must climb down off the gate and go in and explore the garden. You will learn that even to be afraid is to live—so come along, let's live it up.

People, of course, can and do adapt themselves to new conditions—a necessity to survive. You will therefore find it interesting to watch the change in your own attitudes and beliefs as you become familiar with the various functions that make the hospital tick and develop the capacity to realize the necessity of cooperation among all departments to enable the organization to function in a sound manner.

There is little new to be said on the subject of death itself but there is much to learn concerning the unwise handling of this situation. What is there to fear? "Fear of the unknown," someone said. Well, are you afraid to walk outside and get a bus? No, of course not; but the unknown prevails there even more than in death. I wonder if it is fear of the unknown or could it be that you are afraid of facing reality in all its depths. It certainly is not you who are experiencing the unknown.

Let's go take a look at the operating theater. As we near this area you will notice the tempo changes—considerable hustle and bustle but the movements are smooth and there is no lost motion for seconds count.

If you will make notes on what you see and do not understand we will discuss it further in the classroom. I always think it is nice to be able to know that this area is dedicated to the healing of mankind and hallowed by the many lives saved within its walls—that there is such a haven of relief for those suffering and in need of help. Here you observe an operation under way. You are amazed at the perfect orderliness, precision and cooperation which is certainly made evident by the smooth teamwork of all concerned. You can stop holding your noses for there are few, if any, disagreeable odors and if you become ill there are plenty of people here to care for you. Within these walls literally millions of dollars are spent on equipment and skilled personnel so that only the best shall be available for those in need.

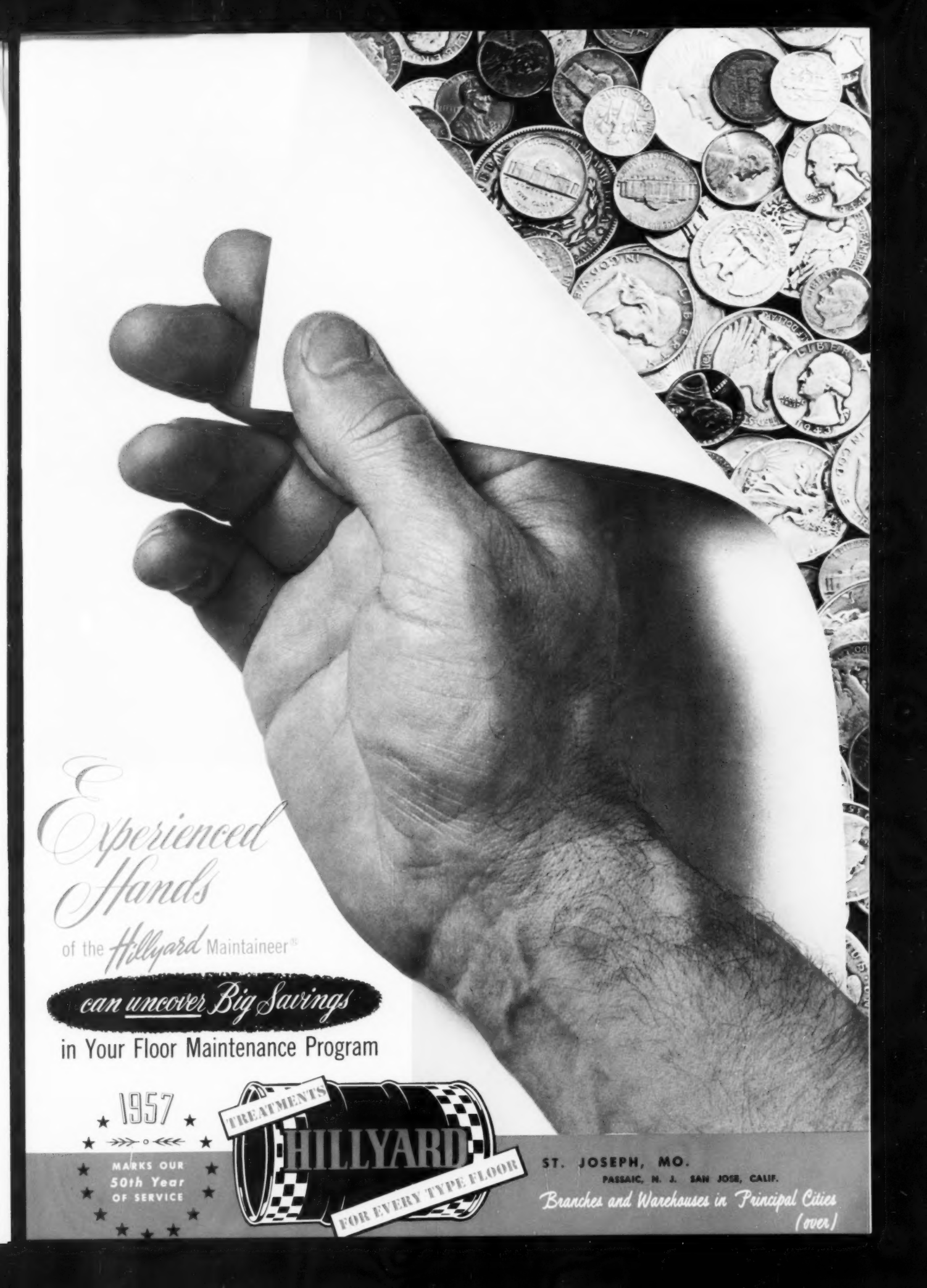
These oxygen tanks should not upset you. Oxygen tanks today do not spell "the end." Instead they are used as a preventive and precautionary measure and therefore you rarely see a floor without them.

Next we are going to meet our guests, individually, and with an objective or a project to be accomplished.

HOW ONE ADMINISTRATIVE HOUSEKEEPING TRAINEE WORKS OUT STAFFING SCHEDULE

Name		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Remarks
LOBBY, OFFICES, DINING AREA									
AIDE		WORK	WORK	WORK	D. O.	D. O.	WORK	DINING WORK	
LABORATORIES AND X-RAY									
DOROTHY		WORK	D. O.	WORK	WORK	WORK	WORK	None D. O.	
O. P. D.									
HELEN		WORK	WORK	D. O.	WORK	WORK	WORK	None D. O.	
FIRST FLOOR									
MARGARET	8-4:30	WORK	D. O.	WORK	WORK	WORK	WORK	D. O.	
DORIS	8-4:30	WORK	WORK	WORK	D. O.	D. O.	WORK	1-2	
PEGGY	8-4:30	WORK	WORK	WORK	D. O.	D. O.	WORK	3-4	
JUNE	8-4:30	WORK	D. O.	WORK	WORK	WORK	WORK	D. O.	
BETTY	8-4:30	WORK	WORK	D. O.	WORK	WORK	WORK	D. O.	
HAZEL	8-4:30	WORK	WORK	D. O.	D. O.	WORK	WORK	WORK 5-6	
O.R.									
JANE	7-3 a.m.	WORK	D. O.	WORK	WORK	WORK	WORK	D. O.	
MARGARET	10-6	WORK	WORK	WORK	WORK	D. O.	D. O.	WORK	
QUARTERS									
BERTHA	8-4:30	WORK	WORK	WORK	WORK	WORK	D. O.	D. O.	
KAY	8-4:30	WORK	WORK	WORK	D. O.	D. O.	WORK	Float WORK	Quarters bathrooms and C.O.
C. O. AIDE	1-9	WORK	WORK	D. O.	WORK	WORK	WORK	D. O.	
RELIEF									
ELIZABETH		D. O.	LABS WORK	WORK O. P. D.	LOBBY WORK	LOBBY WORK	7-3:30 WORK	D. O.	

(Continued on Page 146)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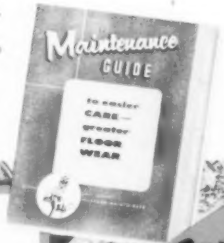

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HOSPITAL PURCHASING FILE contains twelve logical catalog sections, arranged by hospital departments. This series of announcements will cover all twelve, tell you the names of firms that are most eager to serve you and who make available in HOSPITAL PURCHASING FILE catalog information that you can use.

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HOW ONE ADMINISTRATIVE HOUSEKEEPING TRAINEE WORKS OUT STAFFING SCHEDULE

(Continued From Page 144)

Name		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Remarks
RUTH		D. O.	1	C. O.	2	2	8-4:30 WORK	D. O.	
BESSIE		D. O.	4	5	3	3	8-4:30 WORK	D. O.	
JENNIE		D. O.	7-3:30 O. R.	6	6	10-6 O. R.	10-6 O. R.	D. O.	
		D. O.	EXTRA WORK	EXTRA WORK	8-4:30 QUARTERS	8-4:30 QUARTERS	8-4:30 QUARTERS	D. O.	
HOUSEMAN									
JACK	8-4:30	WORK	WORK	D. O.	WORK	WORK	WORK	D. O.	
3-4									
RAY	8-4:30	WORK	WORK	WORK	D. O.	D. O.	WORK	1-2-3 WORK	
5-6									
TED	8-4:30	WORK	D. O.	WORK	WORK	WORK	WORK	D. O.	
BASEMENT AND STAIRS									
GEORGE	8-4:30	WORK	WORK	WORK	WORK	D. O.	D. O.	4-5-6 WORK	
DISPOSAL									
JOHN	7-3:30	WORK	D. O.	WORK	WORK	WORK	WORK	None D. O.	
HENRY	7-3:30	WORK	WORK	D. O.	D. O.	WORK	WORK	WORK	All areas on Sunday
RELIEF									
1		D. O.	5-6	1-2	3-4	3-4	Labs & X-ray	D. O.	
2		D. O.	DISP.	DISP.	DISP.	BASE.	BASE.	D. O.	
GENERAL HOUSEMAN									
ERNEST	8-4:30	D. O.	O. P. D. WORK	Labs & X-ray WORK	WORK	D. O.	O. P. D. WORK	Float WORK	
HUGH	1-9 p.m.	WORK	WORK	D. O.	WORK	WORK	WORK	D. O.	Dining area venetian blinds high dusting

REMARK: After we become adjusted much of this area should be put on nights. Too much traffic. Two general housemen until I get an idea about attendance.

All personnel in 6:30 a.m. to 2:30 p.m. unless otherwise indicated.

Lobby, offices and dining area—1 aide with assistance of houseman for good cleaning.
(Dining area only serviced after each meal)

Laboratories and x-ray—1 aide with assistance of houseman (see notes)

Outpatient department—1 aide with assistance of houseman

We will use the "Team Aspect" throughout patient areas
1 aide to each floor
1 houseman for 2 floors

Operating areas—Need 2 aides—they are under housekeeping. This is a medium size area and very busy. Sundays on duty give good cleaning. This is my ace personnel for Sunday in case of an emergency.

Quarters—30 rooms—but they are large with 2 and 3 beds. Use 2 aides—help one another on change days. Float for bathrooms and check out

Check-out aide—1 aide from 1 p.m. to 9 p.m.

Disposal—2 custodian housemen 7 a.m. to 3:30 p.m.

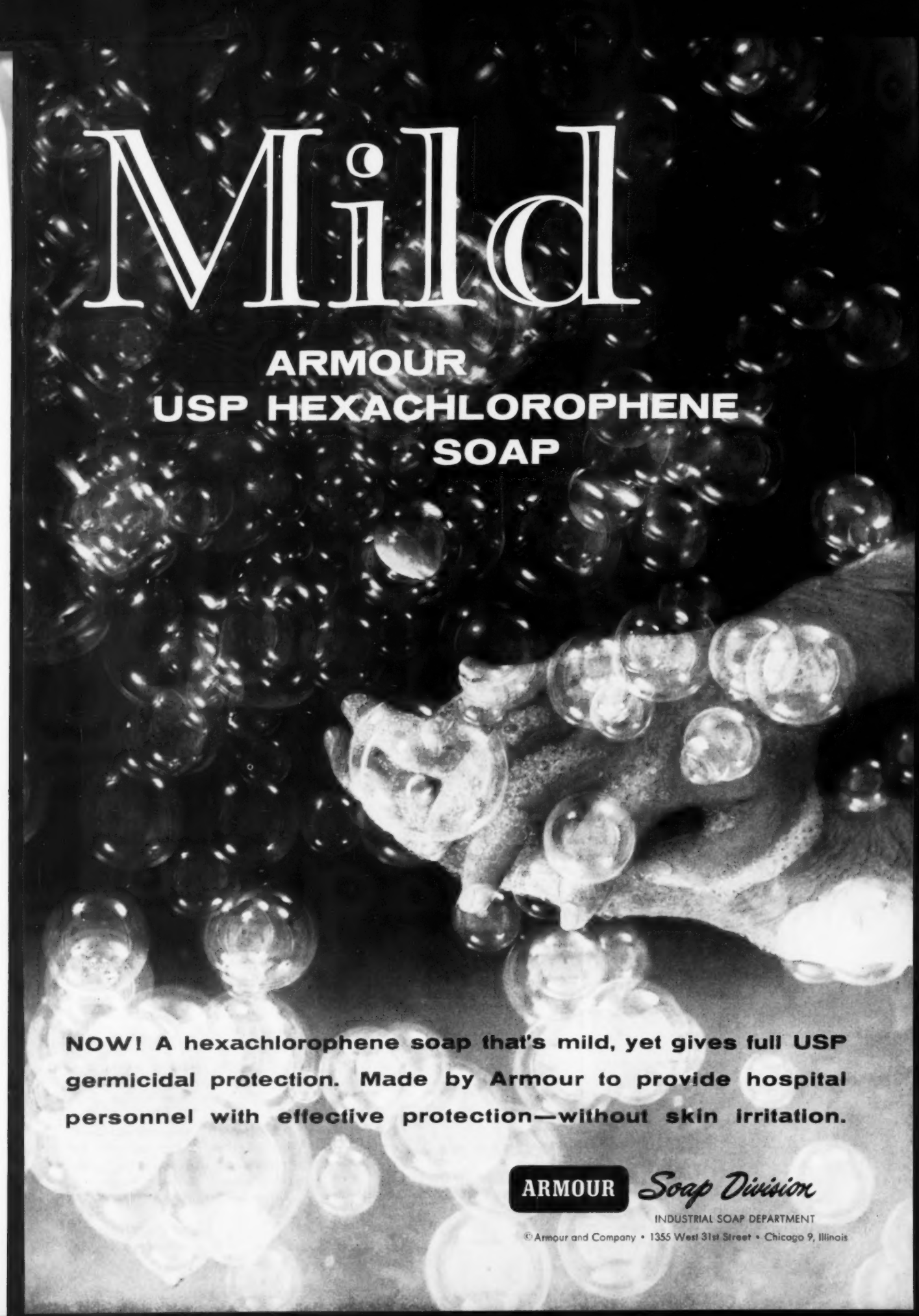
Basement and stairs—1 houseman
Alternate Sunday—can handle patient floors on the Sunday he works

General housemen—2 housemen until I have an opportunity to see how the attendance shapes up. 8 a.m. to 4:30 p.m. and 1 p.m. to 9 p.m.

The project we will be undertaking will be the "distribution of new pillows."

Here, again, we encounter that word "preplanning." When preplanning for this type of project you will discover that the application of *good common sense* is imperative. In order to answer questions for our preplanning we will need information which will involve our conduct, as well as other knowledge. *(Cont. on Page 148)*

LESSON OBJECTIVE	CONTENT	METHODS
Meeting our guests with a project to be accomplished	1—CONDUCT Interdepartmental	Practice in an empty room or use nursing arts classroom
	2—PREPLANNING Why, When, Where, How	
	3—PATIENT APPROACH Conduct Performance Accomplishment Records	Rôle playing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1. Conduct:

You are identified by your pin as a Housekeeping Trainee so you will be entitled to consideration at that level by all departments. Interdepartmental teamwork is essential.

Introduce yourself to personnel in charge.

Special projects should be fully stated.

Ask guidance in procedures as to when you can actually do the work and what areas would be out of bounds.

2. Preplanning:

Why—New pillows replacing old

When—Start next Monday through Wednesday

Where—Top floor: Start with Room No. 1

How—2 Linen hampers with new pillows for just one area (slips have all been put on)

2 Linen hampers for old pillows

Soiled slip covers dropped down chute

(One set of hampers will be stationed at the far end of the area or floor. Keep clipboard on hamper in order to prompt you on areas in which you are not permitted, also to list rooms in which work has not been completed).

Lines of communication sent to floors establishing a date

3. Patient Approach:

Here we learn that the tools are second to *human relations*. Patient privacy and respect, hospital quiet are all part of your conduct. Patient reaction is most important; small things are remembered as annoying. Noise can become a physical nuisance.

Do not peek from behind a door or screen. Enter so you can be seen. This peeking business makes a patient very apprehensive and full of wonder. He can see your feet and knows you are in white but he wonders: "Why in the world don't they come in? What are they planning on doing to me?"

If you have the wrong room, say so, apologize and leave.

The following is an outline of simple steps to help you get in:

Knock lightly—walk into sight.

Introduce yourself.

State your mission.

Complete duties with pleasant talk and leave with objective completed.

Perform the job easily and quietly as possible.

If the patient is asleep:

(a) if possible leave pillow on chair and mark records "collect the old"

(b) if impossible to leave without annoying the patient — mark records "return later"

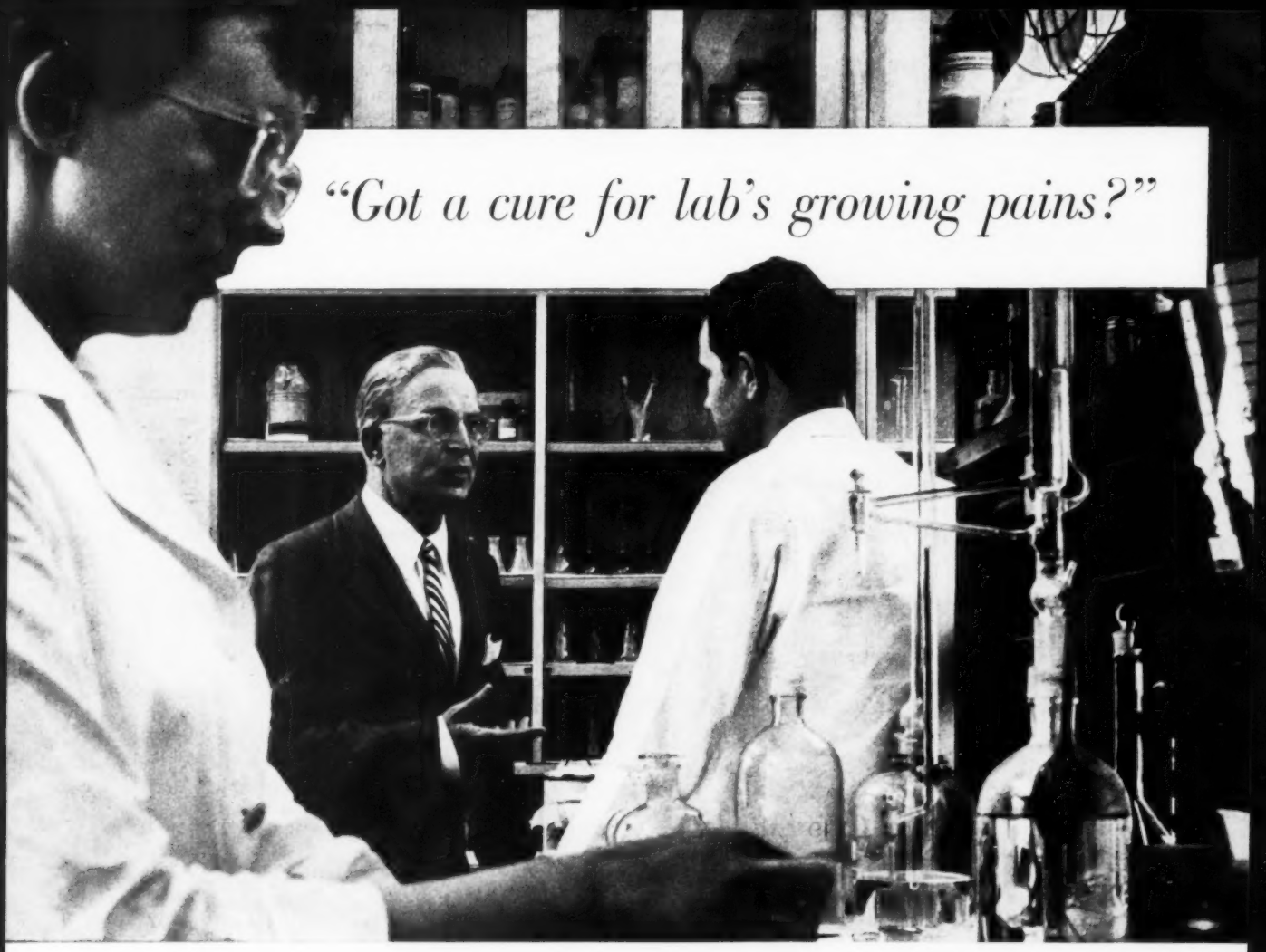
(c) give to Special Nurse and mark "collect the old" later

If the patient does not wish to be disturbed, that is okay. Put pillow in closet or drawer.

Mark records "pick up when room is vacated" (refer to supervisor of this area).

You have done very well in your rôle playing and all of you have been sufficiently difficult as patients to make it very interesting. You will become at ease when lifting the shoulders and removing the pillow after a little further practice. Most patients are not dead weights but can help you by helping themselves.

Try to train yourselves to be considerate of people—those who are concerned about the ill as well as those who are actually ill. Thoughtless remarks often are overheard and cause many a heartache. Personal opinions or condemning remarks should be left for the "soundproof" of your office—or better yet, left unsaid.



"Got a cure for lab's growing pains?"

He has, indeed! *This* administrator is ready. Fact is, he's been waiting for his "patient" to complain.

How did he prepare himself? At the outset, he estimated the patient day load and the operating requirements of each department. But he also instituted regular and timely reports to relate the actual patient mix to the forecast. Reports, for example, which relate the utilization of Lab's services to kinds of patients.

With these *on time* facts before him, the administrator was able to predict that Lab's work load would continue to increase. And thus informed, he was prepared to adjust the budget and authorize added personnel and equipment—*before* the condition could become a crisis.

This is but one example of how proper figure facts can point up situations that demand administrative action. For further evidence, write to us today for your complimentary copy of "Better Patient Care Through Administrative Controls."*

**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

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Doctors Will Give — But Don't Crowd Them

(*Continued From Page 73*)

added or developed. On the other hand, the younger members of the profession feel that the older members ought to give more substantially to the hospital, because they are the ones who have had an opportunity to build up sufficient financial competence to do so!"

Another system sets quotas according to the number of patients staff members have admitted to the hospital during a given base-line period. One doctor who was assigned the responsibility of establishing quotas for the staff in a New Jersey hospital campaign worked out an elaborate point-scoring system based on hospital procedures. An appendectomy was worth 150 points, administration of an anesthetic 25 points, a routine visit to a medical patient 4 points, and so on. Then a clerical staff checked every case history for the preceding year and tallied the number of points for each doctor. Again, the total goal for the staff was divided up among the doctors in accordance with their point ratings. The rationale of this system was explained succinctly by the man who devised it:

"Every doctor will meet his responsibility willingly if he knows the other guy is meeting his."

A less formal method of organizing the staff was described by a doctor who took his hospital responsibilities seriously and was generally credited with playing a leading rôle in the success of a campaign:

"First, we had a meeting of the leading members of the staff," he reported. "At this meeting, we discussed the problem and explained the importance of staff contributions and staff leadership. The director emphasized that there would be no high pressure and nobody would dictate to the doctors concerning their share. Instead, a staff committee was organized to answer questions and help individual members arrive at a fair idea of their responsibilities." **There are some objections and drawbacks to every system. The informal, let-your-conscience-be-your-guide method just doesn't produce as much money as the arbitrary quota system, which also produces more anguish.** The quota based on admissions or hospital procedures performed may work a hardship on some staff members. Thus the doctor who divides his work among two or three hospitals, for example, will get off lightly compared to one who concentrates all his patients in the institution that is conducting the drive. Moreover, the point score based on procedures opens up all the old arguments about the "value" of surgical *vs.* nonsurgical services and, besides, it fails to consider that the busiest man may have done the largest share of charitable work.

MUST BE DEFINITE GOAL

However the quotas are established, experienced campaign directors agree that there must be a definite goal for the staff as a whole, and separate quotas for each individual member, and that staff solicitations should be on a doctor-to-doctor basis as far as possible. In his how-to-do-it lecture for hospital campaign directors, the man with the reputation for taming doctors described the next phase of the campaign in explicit terms:

"After analyzing the assignment of prospect cards and meeting with the committee of doctors who have agreed to do the soliciting, a briefing session

Safety sides do not interfere with use of the patient control panel.

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● This all-new, all-electric "push button" Hill-Rom Hilow bed sets an entirely new standard for convenience, utility and patient comfort, and is the last word in adjustable height bed design and performance. It is designed so that operation of the Hilow feature and adjustment of the backrest and kneerest may be handled by the patient. As shown above, push button controls for patient use are located on the patient's right—in the seat section of the spring. If such patient operation is undesirable, the nurse can easily make it impossible by the use of "cut-out" switches on the motor unit. All switches are mechanically interlocked—no two push buttons can be operated at the same time. Head end and foot end panels are designed by Raymond Loewy.

With the addition of this new "push-button" model Hill-Rom now offers *four* different hilow beds, including both manually and electrically operated models. Complete information on any of these hilow beds will be furnished on request.

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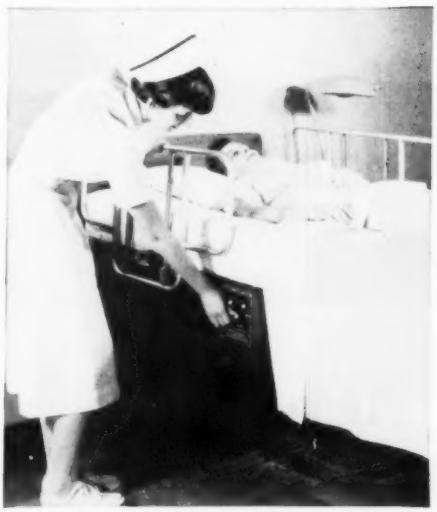

The nurse also finds the push button control panel is conveniently located.

NOW READY!

PROCEDURE MANUAL No. 3

Hilow Beds is the subject of Procedure Manual No. 3, prepared by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom Co., Inc. and author of three leading textbooks on nursing—The American Nurses Dictionary, A Handbook for Student Nurses and The Art, Science and Spirit of Nursing. Copies for student nurses and graduate nurse staff will be sent on request. Address Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Ind.

of the entire medical staff is held at a kick-off breakfast in a hotel on a Sunday morning. That seems to be the most effective time.

"Cards should be distributed to the committee members before this breakfast send-off. No solicitation here unless the doctors request it.

"Report meetings should be scheduled regularly as in any other campaign division—again with an eye on the time limitations of the committee members involved.

"Once the hospital staff and employes have made their pledges to the campaign, the community should then be shown what this 'hospital family' has done. This procedure can be used where any captive constituency group is involved."

"CAPTIVES" PROVIDE PROSPECTS

By a "captive" group, the director explained, he meant any group committed to the project—such as the medical staff of a hospital, or members of a church or other institution seeking funds. "They are captive in that they have a direct affiliation," he said. "It is not like a college or community campaign where you have to build your prospect list. The captive group provides a prospect list already built for you and is there for your campaign purposes."

In addition to the differences in method or approach, obviously, there are other reasons some doctors give generously to hospital campaigns while others sit on their wallets. Foremost, probably, are the differences in personal character, training and philosophy that produce different attitudes toward giving. But the relationship of the medical staff, and the individual doctor, to the hospital board of trustees and administrator is also important. Doctors who feel they are being regimented or pushed around by the administrator and board are likely to respond with less enthusiasm in a campaign than are those who work together harmoniously with the administrator and the board and feel they are fairly treated.

If this is true, hospital-physician relations may be in better shape than it has seemed at times during the last year or two, when so many doctor-hospital squabbles have made headlines. For, any way you look at it, 20 per cent of the community goal in a hospital campaign is a large slice for a small group to give, and the $500 million that doctors have donated to hospitals is a lot of money.

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Problems Multiply at Ironwood Hospital

(*Continued From Page 93*)

later, at the same time appointing another nurse, Mrs. Margaret Mead, as director of nurses.

When Mrs. Endrizzi reported back for work, Mrs. Mead promptly fired her again, and the board backed this move up. Like several members of the seven-man board of trustees, Mrs. Mead is an Albert supporter.

Actually, the board itself, like the community, is divided on hospital issues, and some trustees are inclined to the view that the hospital's problems have been overemphasized. Joseph Desonia, a board member for 35 years, for example, says the hospital is functioning well and much of the criticism is completely unjustified.

"Of course, there is always room for improvement," he told a reporter. "But we have a good hospital here."

This opinion would be disputed by accreditation authorities and others who take a dim view of any hospital with 1265 delinquent medical records and no one with authority to require doctors to maintain records.

These deficiencies, however, do not bother Dr. Albert, who, again, has his own methods. "I believe, and always have, that every patient should have a case record, and all my patients do," he said recently. "But I disagree with the method of handling and safekeeping records at the hospital. I also question what authority will decide what constitutes a complete record and whether the hospital board has the legal power to decide such matters."

In contrast to most medical-legal authorities, Dr. Albert believes that x-ray films are the property of the patients. Tissue removed at operation is also the property of the patient, not the hospital, he contends.

"I also believe that tissues should be examined by a qualified pathologist, but not necessarily by one hired by the hospital," he explained. "The physician should have the right to choose his own."

When the consultant's report revealing the condition of medical records was made public in March, the board reversed itself and reinstated three of the hospital rules that had been dropped when the by-laws were rewritten following the court decision. The reestablished rules provide:

1. The physician is responsible for a complete record of the patient's history and treatment at the hospital.
2. Such records must be submitted to the hospital by the physician and are the property of the hospital.
3. Tissue removed from patients is the property of the hospital and must be examined by a pathologist.

STARTED NEW CONTROVERSY

Immediately, the reinstated rules became the subject of a new controversy —a situation that was acknowledged ruefully by Mr. Desonia. "We're laymen trying to do as good and conscientious a job as we can," he said. "We changed our rules when the courts told us they were wrong. Now, I guess we're being told that what was right yesterday is wrong again today."

That the board is wrong this time and the reinstated rules violate the court order is the opinion of Theodore G. Albert, Dr. Albert's brother, who was prosecuting attorney of Gogebic County when the first suit against the hospital was filed several years ago. In a public statement following restoration of the disputed rules, Attorney Albert said the hospital "is not licensed to do what these rules intend. It should be obvious that there is not only an attempt to force back rules of questioned validity, but to reverse or amend every opinion previously formulated by me and accepted by county governmental units."

Swinging hard at his brother's detractors, Mr. Albert then accused the local press of trying to "make the public believe that Dr. Albert is not keeping records, that he does not forward tissue for study, that he perhaps is keeping tissue, and that he is absconding with x-rays.

"It is *not* true that Dr. Albert steals records," he continued, in an astonishing series of references to charges that, so far as it could be determined, had never been made. "It is *not* true that he does not send tissues away for study. It is *not* true that Dr. Albert is throwing away tissue, or that he is splitting fees."

Mr. Albert's statement, released by a local radio station, concluded with agreement that some kind of investigation was certainly called for. "The Albert family is an institution, if I might say so, in this community," he said, irrelevantly but not without some reason.

As it sifts the evidence to determine whether or not the present hospital board is equal to its task, the County Board of Supervisors is also studying these specific recommendations made by Joseph G. Norby of Milwaukee, the hospital consultant whose report was submitted last November. Mr. Norby said the board of trustees should:

1. **Establish a more formal organizational structure** in the hospital, detailing responsibilities and lines of authority among employes and modifying the by-laws to place greater responsibility on administration in employing, directing and discharging personnel.
2. **Relieve administration of as much departmental detail** as possible to allow the administrator more time to coordinate and check up over-all operations.
3. **Adjust salary and pay schedules** to bring them more nearly in line with practices in better hospitals in the area, with recognition to variations between workers and department heads.
4. **Consider establishment of a central sterile department.**
5. **Relocate clinical and service facilities** for greater efficiency.
6. **Provide for an additional operating room** and renovation of the maternity department.
7. **Provide a "complete face lifting"** for the hospital building to give a better environment for patients, including a systematic plan for replacing obsolete and outmoded furniture.

Finally, Mr. Norby said, the board should "seek to have the County Hospital Act changed in such a manner as to give the governing board authority to regulate and administer the affairs of the hospital in accordance with accepted principles approved by national standardizing organizations representing both the medical profession as well as hospitals."

A change in legislation is the only road back for Grand View, Mr. Norby concluded. "Action on this recommendation is in my judgment of such importance that it will definitely determine whether or not Grand View will move forward and gain respect or progressively deteriorate," he told the board.

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NEWS DIGEST

Western States Ask for Recognition in A.H.A. . . . Mid-Westerners Hear Plea for Christian Charity in Hospitals . . . Tol Terrell Urges Amendment to Hill-Burton at Texas Convention . . . Rôle of Administrator Outlined by Raymond P. Sloan

Western States Seek Recognition in A.H.A.; Hromadka Is Named New President-Elect

LOS ANGELES.—The liveliest sessions at the 27th annual convention of the Western Association of Hospitals here last month were not in the printed program. These were the pre-convention and ex-convention caucuses at which association constituents discussed the building and financing proposals of the American Hospital Association, and the relationship of A.H.A. to its western members.

The western states have been neglected by A.H.A., Alfred E. Maffly, president of the Association of Western Hospitals, reported at one pre-convention powwow.

Only 17 Westerners were appointed to A.H.A. council and committee positions this year, out of 527 available appointments, he said; yet on the basis of geographic membership strength and financial support, there should have been 78 Western appointments.

"We refuse to believe that the majority of smart people in the hospital field are confined in the East, the Middle West, or the South," Mr. Maffly declared. "In fact, we're convinced the West includes many of the outstanding leaders in the American hospital picture, and that A.H.A. has long overlooked our great reservoir of eager and competent leadership. It is our opinion that Westerners have been ignored because we are farther away from the center of activity and have been easily forgotten because we have not demanded recognition."

Following the caucuses and discussion with A.H.A. officers and staff members attending the convention, most of the Western delegations indicated they would seek some modification in the size of the proposed A.H.A. headquarters building and the proposed campaign for contributions from industry.

"The sentiment here is for abandonment of the fund raising drive except for foundations and national corporations," a Western delegate reported, "and for the headquarters building to include about seven or eight stories, instead of 17. The 50 per cent assessment is all right, because it still takes money."

With approximately 3500 registered, the convention itself got off to a fast start with some sharp words at the opening general session from a Los Angeles psychiatrist. Dr. Edward Stainbrook, director of the department of psychiatry at Los Angeles County General Hospital, declared that hospital administration is a form of medical practice, and the most complex form of practice, since it necessitates use of the entire hospital as a treatment method.

The job takes an expert in both

(*Continued on Page* 174)

Association Organized for Record Consultants

CHICAGO. — The Association of Medical Record Consultants, organized here recently, will meet this month to adopt bylaws and membership regulations, it is announced by Adaline C. Hayden, associate editor of standard nomenclature of diseases and operations, American Medical Association.

The new group was formed to encourage the evaluation and improvement of medical records and departments and to study efficiency of record keeping methods. Founders are Stephen S. Henkin, medical records consultant, Health Insurance Plan of Greater New York; Enna C. Black, chief medical record librarian, Hillcrest Medical Center, Tulsa, Okla.; Edward T. Thompson, coordinator of professional services in the division of hospital facilities, Public Health Service, Washington, D.C.; Helen T. Culian, medical records consultant, Rochester Regional Hospital Council, Rochester, N.Y., and Mrs. Hayden.

Rôle of Administrator Told by Raymond P. Sloan At Cornell University

ITHACA, N.Y. — The hospital administrator must provide effective leadership for community health and patient care, combined with business-like management of his institution, Raymond P. Sloan, chairman of the board of directors of The Modern Hospital Publishing Company, told hospital officials meeting at Cornell University recently.

Mr. Sloan spoke on behalf of the Sloan Institute of Hospital Administration, recently established in the Cornell Graduate School of Business and Public Administration.

"Hospital administration is more complex than almost any other type of management," he said. "Comparisons between hospital service and big business, while justified to a certain degree, have tended to create false impressions.

"Economic pressure from rising costs and increasing demands have required that closer and more effective supervision of its management be provided the hospital. Yet it has not always been easy for businessmen serving on the boards of these institutions to recognize that decisions involving large expenditures cannot be influenced wholly by business standards. They must be based on standards of good health and medical care."

Mr. Sloan criticized the "hit or miss methods" used in selecting those who would enter the hospital administration field and charged that inability to handle people was the main weakness of ineffective administrators.

The institute's threefold program of a graduate curriculum leading to the master's degree, research studies in the application of administrative theory and practice to the hospital field, and short courses for administrators and board members also was discussed by Mr. Sloan, who is chairman of the advisory council of the institute.

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Treat Patients With Christian Charity, Speakers at Mid-West Meeting Plead

KANSAS CITY, Mo.—A plea for Christian charity in hospitals featured the opening day of the 29th annual Mid-West Hospital Association here April 24. Speaking at a dinner meeting for Sisters attending the convention, the Most Rev. John P. Cody, bishop of the Kansas City-St. Joseph diocese, said that institutions become lifeless when charity is taken away.

"Then the institution becomes not a help in many cases, but a deficit," he declared. "We must remind ourselves that we are not running hospitals for ourselves. Let us measure our success not in material gain or in technological skill, but in love of our fellow man."

Even in technological terms, hospitals are not doing as well as they should be doing, Dr. David Littauer, executive director of Jewish Hospital, St. Louis, told the convention. For example, standards of the Joint Commission on Accreditation of Hospitals should be considered as true minimum standards, far below the optimum achievement all hospitals should strive for, Dr. Littauer said.

If an autopsy ratio of 15 or 20 per cent indicates good performance, 50 or 75 per cent should be the goal, he urged. Similarly, hospitals should conduct preventive medical programs, education programs, and research to a much greater extent than is practiced at present.

"In the past, too much emphasis has been placed on quantity rather than quality in determining standards," Dr. Littauer told a medical record librarians' meeting. "As we advance toward soundly established standards of quality, the job of the medical record librarian will become more complicated, which in turn will require higher standards of training and education for librarians."

A record breaking crowd of more than 2500 administrators, assistant administrators, and other hospital personnel attended the convention.

The delegates heard papers and discussions by leading authorities on such diverse topics as disaster planning, personnel shortages, the hospital of the future, and the development of hospital-community relationships.

Local disasters are not separate hospital challenges but must be planned against together, was the theme developed by Dr. Curtis H. Lohr, St. Louis, at the opening session. Sister M. Maurelia, Blackwell, Okla., described to the association the tornado which devastated that town in 1955.

Local hospitals that plan work cooperatively on community needs are the key to health progress, and a city with hospitals that avoid costly duplication of service, that plan together for unfilled needs, such as care of the elderly, will get the community job done best at least cost, Tol Terrell, president-elect of the A.H.A., told the opening meeting.

In a projection of hospital services, Mr. Terrell said hospitals are becoming

(*Continued on Page* 170)

University of Washington Will Establish Course in Executive Housekeeping

SEATTLE.—A four-year course in executive housekeeping has been approved by the University of Washington here for inclusion in the school of home economics, it was announced last month.

The course, which was promulgated by the Puget Sound chapter of the National Executive Housekeepers Association, with the approval of the national board, will be open to students next fall, and will lead to a bachelor's degree in institution administration. Subjects to be covered in the four years include English, health education, chemistry, textiles, sociology and psychology, economics, personnel management, purchasing and material management, work simplification, institutional management, foods and nutrition, home furnishings and child care, and speech, among others. Following graduation, students will be expected to serve an internship similar to that offered to students of hospital administration.

With a degree course in executive housekeeping established at the University of Washington, the N.E.H.A. has tentative plans for instituting similar courses in other state universities and colleges, according to Madge H. Sidney, director of housekeeping, Doctors Hospital, Seattle, and co-chairman with Lillian LaChappelle of the Puget Sound chapter's education committee. A nationwide publicity and recruitment program is also in progress, Mrs. Sidney stated.

Hospitals' Immunity for Medical Negligence Voided by N.Y. Court of Appeals

ALBANY, N.Y.—A rule of law giving New York hospitals immunity for medical negligence of their employes was reversed by the State Court of Appeals here May 16, according to a *New York Times* report. The court ordered a new trial of a damage suit brought by a Brooklyn woman against her physician and St. John's Episcopal Hospital, Brooklyn.

The woman was burned during an operation. A state supreme court jury awarded her $2500 damages against her physician and $12,500 against the hospital, but the appellate division dismissed the case under the nonliability rule.

Associate Judge Stanley H. Fuld of the court of appeals pointed out that the liability of a hospital for injuries suffered by a patient through negligence has depended on whether the negligent act was "administrative" or "medical." (New York hospitals have for some years been held liable for administrative acts of their employes.)

"That difficulty has long plagued the courts," the judge said, "and indeed, as consideration of a few illustrative cases reveals, a consistent and clearly defined distinction between the terms has proved to be highly elusive."

Attempts to make distinctions in acts of liability "cannot help but cause confusion, cannot help but create doubt and uncertainty," he said. "Hospitals should, in short, shoulder the responsibilities borne by everyone else. There is no reason to continue their exemption from the universal rule of *respondeat superior*."

Five of six other judges agreed with Judge Fuld. But Chief Judge Albert Conway said he concurred in ordering a new trial because the act of negligence in the case was "administrative." He said the court should "stop there" in its findings and not go on to overrule the doctrine exempting hospitals from liability.

Grants to Three Hospitals

NEW YORK. — Three hospitals have been announced as the principal beneficiaries of a recent grant from the William J. Wollman Foundation. Given $1 million each were New York University-Bellevue Medical Center, for a children's pavilion; Lenox Hill Hospital, for reconstruction, and Mount Sinai, for a psychiatric pavilion.

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Amend Hill-Burton to Provide for Renovation, Tol Terrell Urges Texas Hospital Association

HOUSTON, TEX. — W. P. Earngey Jr., administrator of Harris Hospital, Fort Worth, was named president-elect of the Texas Hospital Association at its 28th annual convention here May 14 to 16.

Incoming president is the Rev. Bolton Boone, administrator of the Methodist Hospital of Dallas. Other officers named were: vice president, Sr. M. Annella, administrator of St. Ann Hospital, Abilene; treasurer, F. S. Walters Jr., administrator of Northwest Texas Hospital, Amarillo, and trustee, Ted Bowen, administrator of Methodist Hospital, Houston.

Meeting concurrently were the Texas Conference of Catholic Hospitals and associated groups of auxiliaries, medical record librarians, nurse anesthetists, operating room nurses, purchasing agents, and hospital chaplains.

Tol Terrell, president-elect of the American Hospital Association, urged an amendment to the Hill-Burton Act to provide for low interest mortgage loans for renovation needs. "In many hospitals, there are needs to the extent of improving facilities—in others there are entire sections that need rehabilitating and renovating physically," he said. "In my opinion, the renovation needs exceed the need for additional hospital beds."

A. J. Swanson, president of the American College of Hospital Administrators and chairman of the Ontario Hospital Service Commission, Toronto, praised a two-year nursing curriculum now operating in Canada as a means of reducing the nurse shortage. Two years of schooling and a third year of internship have given Toronto Western School of Nursing a surplus of candidates each year and resulted in a higher rate of retention of students, Mr. Swanson said. Using the third year for internship guarantees a pool of excellent nurses, he said. More and more Canadian schools are instituting the two-year curriculum, he added.

Mr. Swanson also described the Ontario health plan, which combines insurance coverage and federal subsidy Recent legislation allows individuals to buy hospital insurance subsidized by the Canadian government, he said. Under the plan the patient is given hospital care and, in return, is assessed a premium similar to private plans.

The responsibilities of the doctor, trustee and administrator were discussed by Everett W. Jones, hospital consultant and technical adviser to The MODERN HOSPITAL; Dr. James D. Murphy, past president of the Texas Academy of General Practice, and Raymond P. Sloan, chairman of the board of directors of The Modern Hospital Publishing Company.

Dr. Murphy, discussing the trustee, urged that economies be made in expenses other than the administrator's salary. Trustees must pay a salary high enough to attract and hold a high grade executive, he said.

Eleven areas in which a doctor has responsibilities toward the patient and the hospital were outlined by Mr. Jones. The doctor must consider how his handling of the patient in the office affects credit and collection problems and the patient's attitude toward the medical profession and hospitals in general, he said. The physician should have a thorough knowledge of hospital facts and be accurate in giving these facts to patients, their relatives, and the public, he added.


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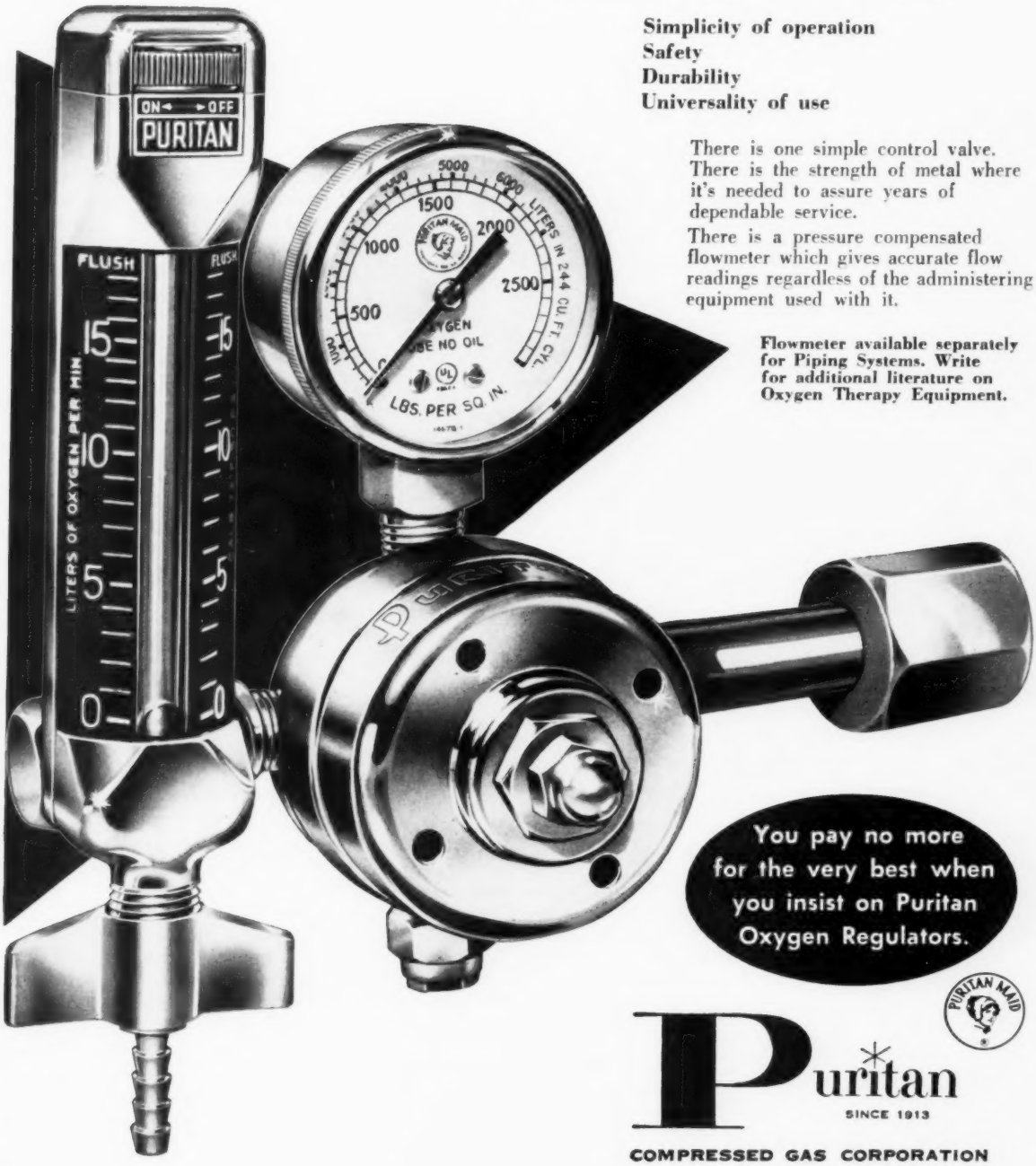

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Objective Student Counseling Stressed by National League for Nursing Speakers

CHICAGO.—Nurse recruitment must be treated as more than a publicity or promotion effort for nursing as a career, a panel of six speakers told National League for Nursing convention delegates here last month. About 3250 delegates attended, with another 2300 meeting for the National Student Nurses' Association.

Objective counseling, both for prospective students and those already enrolled in nursing schools, and organized activities to let each community know what nursing education facilities exist are the key jobs facing nurse recruitment workers in the future, panel members said.

Mrs. Robert M. Jones, chairman of the Washington state careers committee, said that students must be guided into the types of educational programs that will prepare them for their coming job responsibilities. "Two-thirds of today's nurses work directly with patients where there is some supervision. One-third work more independently, supervise others, teach or administer nursing service," she said.

"If this latter third are to be prepared for the responsibilities they must carry, career promotion for nurses must look farther for 'college material' and, while increasing the number of students who enter diploma programs, help to guide a larger proportion of our applicants into basic programs that will start them off with their bachelor's degrees," she said.

Martha Eisele, director of guidance and counseling in the department of nursing, University of Kansas School of Medicine, said that if a nursing student is given the right influence, she will find the educational tools to prepare for a job which may demand more of her than she can give. "If she is made to feel guilty, on the other hand, for even considering anything but bedside nursing, a natural zest for administration or teaching can be killed easily," she said.

The extent to which the two types of basic education nursing programs —diploma and baccalaureate degree— must expand was indicated in a study titled "Nurses for a Growing Nation," which was issued at the convention.

Relating educational patterns in nursing to the job responsibilities of professional nurses, the study reported that nurses who work under supervision, such as bedside nurses in hospitals or doctors' office nurses, train in diploma and associate degree programs. This group comprises 67 per cent of the professional nurses in active nursing jobs.

The remaining 33 per cent who become head nurses, public health staff nurses, teachers, administrators and supervisors prepare initially in baccalaureate degree programs, the study reported. The nurses in this group who go on to top leadership positions undertake graduate study.

From a present 430,000 professional nurses, or a ratio of 258 to every 100,000 people, the nation will need 600,000 nurses by 1970 to increase the ratio to 300, and 700,000 nurses to raise the ratio to 350.

If nursing continues to attract its present proportion—4 per cent—of the college age girls, the profession can expect to reach the 300 ratio by 1970, the study pointed out. However, a national goal of 350, already reached or exceeded by six states, can be at-

(*Continued on Page* 166)


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(Continued From Page 162)

tained only if some of the current trends in nursing are reversed. More students must be attracted to nursing than present trends anticipate and the withdrawal rate in schools of professional nursing must be reduced to reach the goal, the report indicated.

The formation of a Council on Practical Nursing within the present structure of the National League for Nursing was discussed by 400 practical nurses, nurse educators, and others. Special panels on practical nursing brought out the fact that practical nurses and auxiliary workers increased their numbers by 204 per cent from 1946 to 1955, while professional nurses added 75 per cent to their ranks in the same period.

A dramatic presentation of two versions of nurses' handling of a patient illustrated the kind of adaptation that a proposed patients' bill of rights may eventually include. The bill, initiated at the suggestion of Ruth Freeman, league president, will set forth what the patient and nurse can expect from each other. Muriel C. Henry, director of careers of the league, pointed out that for therapeutic reasons there had generally been a shift from a nurse's "doing for" the patient to having the patient involved in his own care. The emotional factor in the patient's recovery will be considered in the bill, which is to be drawn up with the help of a committee that includes former patients.

Miss Freeman was reelected president of the league.

NEW PRESIDENT IN NEW MEXICO

Left, new president of the New Mexico Hospital Association, Roy H. Turley, administrator of Espanola Hospital, Espanola, accepts the gavel from Ray Woodham, outgoing president, administrator of Presbyterian Hospital Center, Albuquerque. The 12th annual convention of the association was held in Albuquerque from March 11 to 13.

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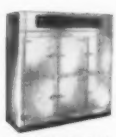

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Study of Conditions at Bellevue Hospital Results From Criticism

NEW YORK. — Public criticism of Bellevue Hospital by medical leaders and denials by city officials have resulted in a new study of conditions at the 2684 bed institution, with a view toward reconstruction and modernization next year.

At least, the city department of hospitals' request for capital funds in 1958 will include a plea for enough money to begin improvements. This has been promised in a report submitted to Mayor Robert Wagner by a special committee of the board of hospitals, policy making arm of the department. The report was the result of a survey ordered by the mayor following published charges of alleged physical, medical and personnel deficiencies at Bellevue, a city hospital.

The committee's report has been turned over to Dr. Morris A. Jacobs, commissioner of hospitals, for a "thorough investigation" of charges.

The criticism reportedly arose after medical leaders attended a planning session in April for the proposed expansion of the city's Public Health Research Institute with municipal funds as a part of the department of health. They had agreed that a modest enlargement of the institute was necessary but objected to the diversion of city funds to a seemingly large research project when the money could be used in the hospital department to improve existing facilities, it was reported.

Dr. Dickinson W. Richards, head of Bellevue's division of the Columbia University College of Physicians and Surgeons, reacted to the proposed expansion by stating that good medical research necessitated good medical care of patients and that, if the money were used in this way, research funds available to the various universities and research institutions would be more valuable.

The medical schools of Cornell University and New York University also are affiliated with Bellevue.

Dr. Richards charged that over the last 20 years the hospital had been "shamefully neglected" by the city and should be rebuilt. He asserted that the city did not furnish adequate physical facilities or sufficient personnel and that shortages of medicine, laboratories and nurses hampered medical care. His charges were promptly denied by Dr. Jacobs, who became commissioner of hospitals in January.

On May 1, Dr. Jacobs toured Bellevue and said that he had found "certain plant inadequacies" which were being corrected and that "patient care is very good." He again denied shortages of medicine and added that employes were constantly being added to the staff. He also emphasized that on April 25 the city board of estimate had authorized $85,000 for a study by architectural consultants to determine what buildings needed rebuilding or renovation.

The same day the Bellevue House Staff Council, representing 450 interns and residents, backed Dr. Richards' charges as "completely correct" and "if anything, conservative."

Support came also from New York University in the person of Dr. George E. Armstrong, vice president for medical affairs. Dr. Armstrong reported that the N.Y.U. medical faculties endorsed Dr. Richards' statements and said:

"It is time New York City ceased the stop-gap, temporizing, piecemeal repairs of the outmoded hospital buildings and provided both a complete

reconstruction of Bellevue Hospital, together with provisions for essential modern patient care and laboratory servicing."

Two days later the directors of the eight medical and surgical divisions at Bellevue demanded that the city tear the building down and rebuild it. They reportedly decried the $85,000 appropriation for a consultants' study, saying that in 1940 and in 1946 plans for a new hospital were completed but did not result in construction of a new plant.

Members of the Cornell University Medical School, which reportedly had planned to issue a separate statement, presented their views at the division chiefs' meeting. Dr. Thomas P. Almy, director of the Cornell medical division, said that "there is no doubt that the majority of doctors in our division agree with Dr. Richards on this."

Reconstruction of Bellevue has been a part of the department of hospitals' master plan since 1949, according to the report submitted to Mayor Wagner. At that time a $150 million hospital construction bond issue was approved by the voters.

In 1954 various projects totaling $80 million were temporarily deferred, including $32 million for Bellevue. Construction of four new city hospitals made it necessary to restudy Bellevue's needs, it was reported. The department asked for $100,000 two years ago for an architectural study, but action was deferred because of recommendations made by the Hospital Council of Greater New York following a survey of hospital needs in lower Manhatten, the committee stated.

In June 1956, the board of hospitals asked that immediate steps be taken to "proceed with the study and preparation of plans and designs for the replacement and reconstruction of Bellevue Hospital Center."

Early this year, Dr. Randolph A. Wayman, supervising medical superintendent of Bellevue and a city official, issued his 1956 annual report, in which he said: "In comparison to other institutions of the municipal system Bellevue structures are absolutely antiquated. A new up-to-date hospital is urgently needed. . . ." This report also spoke of decrepit buildings, a shortage of nurses, and other deficiencies.

On May 8 the board of hospitals met with the mayor. At this time he asked for the special committee and gave it 48 hours in which to study the situation and make recommendations to him.

The committee's report, which included the plea for funds in 1958, asked that adequate physical facilities be provided as soon as possible and upheld the medical staff's complaints that laboratory facilities and personnel were inadequate. The mayor reportedly indicated that the board of estimate would act promptly to remedy the latter condition, without waiting for completion of physical improvements.

He also stated that delays in reconstruction were the result of direct advice given the board of estimate by the board of hospitals and other medical experts.

After the report was issued, five lay committees working at Bellevue wrote to Mayor Wagner supporting the charges made by medical leaders and urging him to announce publicly what the city will do to improve conditions "and when."

The amount reportedly to be sought by the department of hospitals for modernization would be set by the architectural consultants. Estimates vary from $40 to $75 million.

Mid-West Speakers Plead for Christian Charity

(Continued From Page 160)

health and medical centers serving all the community rather than just acutely ill patients. As medical science expands, hospitals must expand their research and clinical programs, and this costly process must not be assessed against the bed patient only through higher daily rates, Mr. Terrell pointed out, for it boils down to the community approach.

Taking a look at the human side of hospitals, administrators found room for improvement. It was pointed out at a panel discussion that hospitals sometimes act as if the public should be cultivated only when a new drive for funds is needed. Good relations start with the admitting clerks, and interest in the patient's welfare should start with them and extend to the patient from every employe and staff member, speakers on the panel emphasized.

The good hospital is clean and efficient but, more than that, it is human. The doctor should arrange that the incoming patient avoids meaningless delays or misunderstandings by planning in advance, members of the panel pointed out.

Reassurance can be a bigger help to a worried patient than quieting drugs, in many instances, the panel told the delegates.

NEW OFFICERS

New officers elected by the association were: president, Bryce L. Twitty, administrator, Hillcrest Medical Center, Tulsa, Okla., president-elect, James C. Carr Jr., administrator, Natrona County Memorial Hospital, Casper, Wyo.; treasurer, Carlos J. R. Smith, administrator, Helena Hospital, Helena, Ark.; delegate-at-large, Herbert A. Anderson, administrator, Lincoln General Hospital, Lincoln, Neb.; and trustees: H. E. Rice, Denver; Karey Fuqua, Lawton, Okla.; Richard Scruggs, West Memphis, Ark.; Sister Mary Ferdinand, Salina, Kan.; Earl Ireland, Sheridan, Wyo.; Harry Panhorst, St. Louis, and Paul Fineman, North Platte, Neb.

Mrs. Margaret S. Barber, Kansas City, Mo., was appointed full-time executive secretary of the seven-state association. Mrs. Barber has served in the dual capacity the last two years of part-time administrative assistant at Bethany Hospital, Kansas City, Kan., and part-time executive secretary of the 800 hospital organization.

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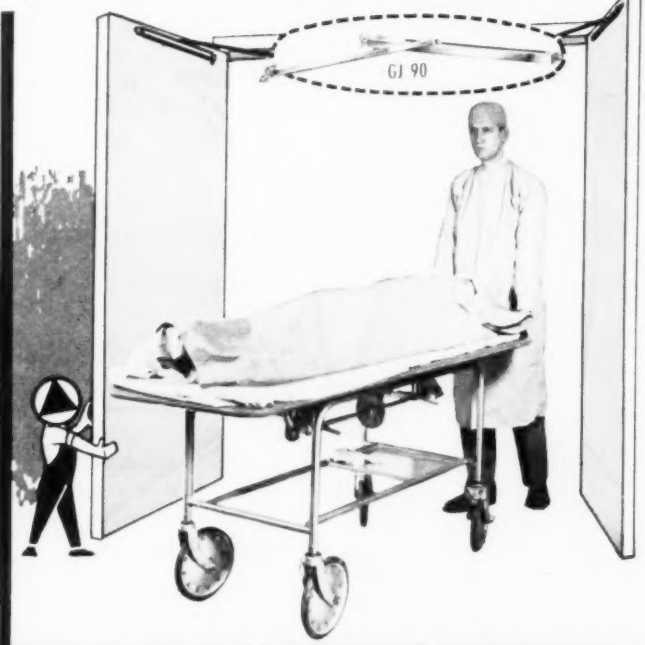

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(*Continued From Page* 158)

medicine and social science, Dr. Stainbrook said, because tension and uneasiness in a hospital are quickly communicated to patients and can become a part of their illness.

"What hospitals need is a doctor for the hospital, an expert in both medicine and social science who can diagnose and treat the organizational uneasiness of the hospital," Dr. Stainbrook said. "All organizations are increasingly concerned with worker unrest, apathy, low morale and frequent job changes. Hospital administrators must be aware that modern science shows this disease in the hospital system can affect not only the psychology of patients in the hospital but their bodily functions as well."

Administrators must learn to sense, see, diagnose and cure human tensions in the hospital organization, Dr. Stainbrook insisted. Especially, he warned against:

1. Forcing patients to accommodate to the "hospital strait jacket."
2. Little attention to the importance of employe status as measured by working conditions.
3. House organs filled with material that interests the administrator but doesn't help employes.
4. Decisions by chiefs of services which don't take into consideration the nurses' knowledge of patient need.
5. Poor communication up and down the hospital chain of command.

A thorough understanding of human emotions and motivations must be added to the hospital administrator's tools in order for him to do his job effectively, Dr. Stainbrook concluded.

Ralph Hromadka, superintendent of the Santa Monica Hospital, Santa Monica, Calif., was named president-elect of the association during the convention. He will succeed Guy M. Hanner, Good Samaritan Hospital, Phoenix, Ariz., who became president when Mr. Maffly retired during the convention.

At a community hospitals section meeting, Dr. Joseph W. Telford, president of the California Academy of General Practice, said the California Medical Association was "still not satisfied" with the way the Joint Commission on Accreditation of Hospitals works and thinks the commission program should be decentralized.

There should be a hospital appoint-

ment for every competent doctor of medicine, Dr. Telford declared. However, he acknowledged, there is no place on any hospital staff for an incompetent physician.

Disputes between general practitioners and specialists are essentially matters of economic competition, Dr. Telford stated. Every physician appointed to a hospital staff has an obligation to support policies approved by the staff and administration, he said; general practitioners should have a greater voice in policy making, he said.

Speaking on the same program, A. A. Aita, administrator of the San Antonio Community Hospital at Upland, Calif., said the general public is becoming increasingly conscious of the value of hospital accreditation.

James E. Ludlam, legal counsel for the California Hospital Association, pointed out that there is a growing tendency for Blue Cross and other third-party payers to confine authorization and payment for care to accredited hospitals, and for courts to find against hospitals in cases of negligence more readily when hospitals do not meet standards of accreditation.

To recruit and hold competent nurse anesthetists for small hospitals, administrators must help make life in small communities more attractive to these girls, Virginia Welch, administrator of the Good Samaritan Hospital, Corvallis, Ore., told the group. In addition, she said, nurse anesthetists must be helped to continue their training and keep up with modern technics.

"There is no excuse for second rate anesthesia service in the small hospital," she said. "Don't forget that your anesthetist must have adequate rest and vacation time and must be paid a salary in keeping with her great responsibilities," she concluded.

As he did at several other regional hospital conventions this year, Dyke Brown, vice president of the Ford Foundation, explained how the foundation's program for hospitals was developed, and how the Ford grants have been used to extend hospital service.

"Our hospital program is large by philanthropic standards, but it is only a small drop as far as the continuing needs of hospitals are concerned," Mr. Brown said. "It is increasingly clear that the job of providing adequate hospital care for our citizens is too big for any one agency or organization. Its accomplishment depends on how well these needs are understood by private citizens and organizations, and on their willingness to contribute ideas, time and financial support to the joint community effort."

In addition to Mr. Hromadka, other officers elected by the association were: first vice president, Wesley G. Lamer, Physicians and Surgeons Hospital, Portland, Ore.; second vice president, Paul Hoff, Bannock Memorial Hospital, Pocatello, Idaho; third vice president, Sister Mary Bede, Sacred Heart Hospital, Spokane; treasurer, Joseph Zem, St. Luke's Hospital, San Francisco.

Folsom Calls Health Coverage "Too Limited"

WASHINGTON, D.C. — Health coverage still is too limited and many policies too restrictive, Marion B. Folsom, Secretary of Health, Education and Welfare, told the Health Insurance Association of America here recently.

Two out of three Americans have no insurance against general medical expenses, Mr. Folsom said. Two-thirds of those with income under $2000 a year have no insurance against medical care costs, he said.


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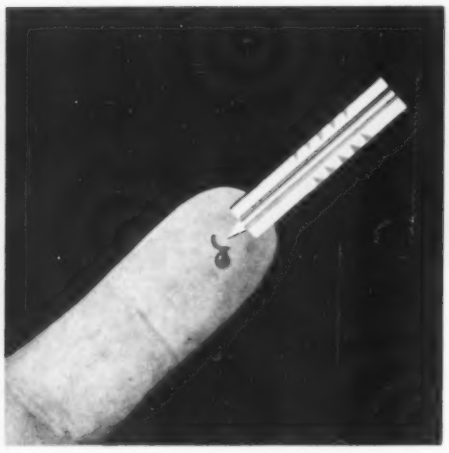

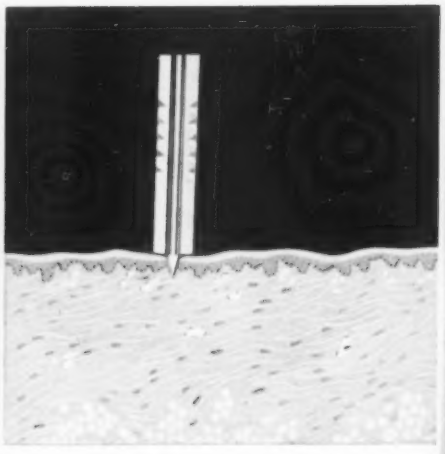

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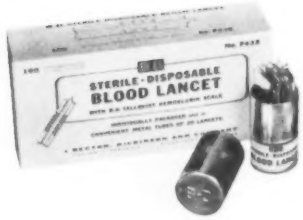

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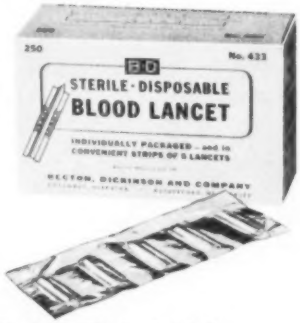

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Conferences for Nurses Improve Attitudes, Psychiatrists Report

CHICAGO.—Better attitudes toward patients and greater success in dealing with doctors and supervisors resulted from a program of weekly conferences for nurses, at which interpersonal relationships were discussed freely, a group of psychiatrists reported here last month at the annual meeting of the American Psychiatric Association.

Dr. Leonard Levy, chief resident in psychiatry at Queen Mary Veterans Hospital, Montreal, Que., and a group of associates from the departments of psychiatry at Montreal General Hospital and McGill University reported that the director of nursing made arrangements for charge nurses in a large general hospital to hold weekly conferences with the nurses they supervised, in an attempt to promote better interpersonal relationships. The department of psychiatry met weekly with the charge nurses, and psychiatrists led the conferences.

Describing the results after one year, Dr. Levy and his associates said, "The principal goal is improvement in the nurse's work relationship and in her understanding of human and psychiatric problems. As a result, the development of better attitudes toward difficult patients and to their own rôle, and their dealings with authoritarian figures such as matrons and doctors, occurred."

One group began its discussions with weekly case presentations, the authors reported. "Gradually, psychiatric and social problems were freely discussed by the nurses, with increasing reference to their own personal difficulties," they said.

The second group continued with the case presentation technic, with patients discussing their own difficulties in the presence of nurses.

In another paper on patient activity and movement in psychiatric units, Dr. Lucy D. Ozarin, director of the A.P.A.'s Architectural Study Project, said that movements of patients in the psychiatric wards of five general hospitals were observed during the study.

"Observation showed that patients prefer to be in small groups and that they desire privacy at least part of the time," Dr. Ozarin said. "Large dayrooms which are usual in psychiatric wards were rarely occupied by more than half the patients at any one time, unless they were also used for dining. Some patients were always found to be in bedrooms, the only place where they could have privacy."

Several speakers at the meeting stressed the need for hospitalization insurance protection for psychiatric patients. Reporting experience in covering psychiatric illnesses in the Cleveland Hospital Service Association, John R. Mannix, executive vice president of Cleveland Blue Cross, said the Cleveland plan had been a pioneer in providing coverage of psychiatric illness.

"Until there are clearly understood entities of illness and accepted patterns of care and predictable costs, it appears that some sort of artificial restrictions or limitations may be necessary," he said.

"Development of patterns of care and standards of cost can be accomplished best by psychiatry itself. Insurance can only administer benefits according to the criteria established by the profession. With clear criteria for sale and administration of psychiatric benefits, the insurance mechanism can channel additional funds into psychiatric care to the advantage of the profession and the public," he said.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Atlantic City, N.J., Sept. 28-30.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Regional Membership Conferences: Region 13, Berkeley, Calif., June 10-14; Region 12, Houston, Tex., July or August; Region 9, Chicago, Nov. 11-15.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN HOSPITAL ASSOCIATION, national convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Palmer House, Chicago, June 22-29.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, international convention, Sheraton Park Hotel, Washington, D.C., June 8-13.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 15-18.

CALIFORNIA HOSPITAL ASSOCIATION, Lafayette Hotel, Long Beach, Oct. 30-Nov. 1.

COLORADO HOSPITAL ASSOCIATION, Hotel Denver, Glenwood Springs, Oct. 10, 11.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Quebec, June 24-26.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

INDIANA HOSPITAL ASSOCIATION, Student Union, Univ. of Ind. Medical Center Campus, Indianapolis, Oct. 9, 10.

INTERNATIONAL HOSPITAL FEDERATION, Lisbon, Portugal, June 3-7.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 6-8.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 21, 22.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 9-11.

NATIONAL GERIATRICS SOCIETY, Hotel Statler Washington, D.C., June 11-13.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 17, 18.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 28-30.

SOUTH DAKOTA HOSPITAL ASSOCIATION, fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 18.

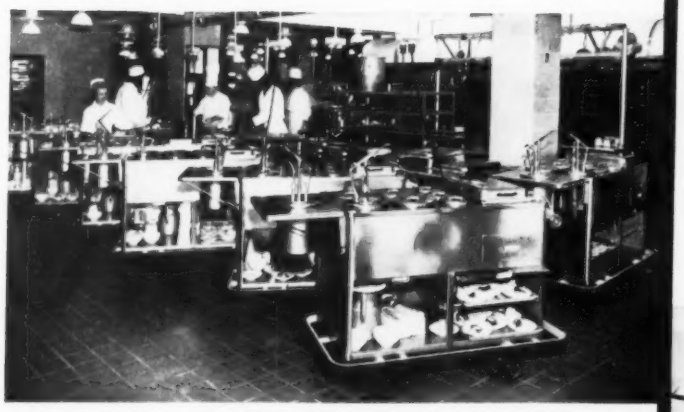
VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Greenbrier Hotel, White Sulphur Springs, Aug. 1-3.

WORKSHOP ON ASEPTIC TECHNIC, University of Minnesota Center for Continuation Study, Minneapolis, Sept. 16-26.

1958

ALABAMA HOSPITAL ASSOCIATION, Hotel Stafford, Tuscaloosa, Jan. 23, 24.



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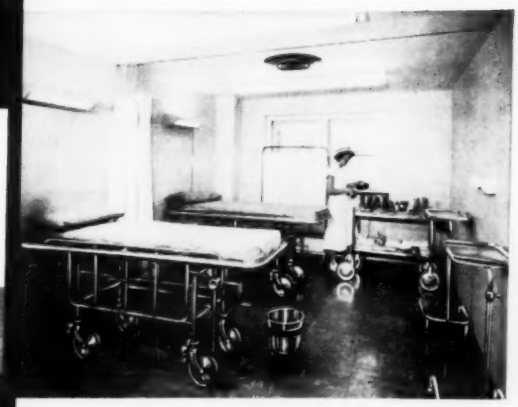

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(*Continued From Page 70*)

as the responsibility of the physician is concerned, are changing very rapidly," he pointed out.

The physician staff member is responsible for his own acts, Mr. Stump explained, and if he is guilty of negligence, his negligence cannot be imputed to the hospital. "But both he and the hospital may be responsible for the same act," he said, "the hospital because it negligently admitted him to staff membership, and the physician because he was negligent in caring for the patient."

The determination of negligence is "shadowy," Mr. Stump concluded, and there is no clear and sharp line easily discernible to divide proper care from negligence. "What the ordinarily cautious and prudent person would do in the exercise of ordinary care and skill is a question of fact on which evidence will be heard by the court," he said.

At a Tri-State program sponsored by students of hospital administration and presented as a memorial to the late Dr. Malcolm T. MacEachern, for many years director of the Tri-State Assembly, Richard G. Dunning, graduate student in hospital administration at the University of Chicago, discussed methods of self-education for administrators. In addition to observation, reading and experiment, Mr. Dunning said, the alert administrator should consider interviews as an educational experience. Properly planned and conducted, the interview can be rewarding and informative, he pointed out.

"We want the background of an interviewee," Mr. Dunning said. "When the interviewee is known, it is the subject matter that is paramount. Before the interview starts we want to know its personnel, type, purpose, design and content, including what is to be avoided."

When the interview is concluded, Mr. Dunning suggested, a postmortem is vital. "Ask yourself specific analytical questions," he urged. "Did I get what I wanted? If not, why not? How could I have gotten more, or gotten it more quickly? Where did I go wrong? What did I learn?"

Leonard W. Hamblin, administrator of the Blessing Hospital, Quincy, Ill., and president of the Tri-State Assembly, presented special citations to Laura Jackson in recognition of her years of service as Dr. MacEachern's assistant in planning Tri-State programs, and to

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Dyke Brown, vice president of the Ford Foundation.

Tri-State awards of merit were given to the Rev. Joseph A. George, administrator, Evangelical Deaconess Hospital, for Illinois; Dr. Roger W. DeBusk, administrator, Grace Hospital, Detroit, for Michigan; Guy Spring, executive director of Blue Cross Hospital Service, for Indiana; and Edmund B. Fitzgerald, president of the Northwestern Mutual Life Insurance Company and leader of the United Hospital Fund campaign in Milwaukee, for Wisconsin.

Specialist Dispute Cost Iowa Hospitals $58,000

(*Continued From Page 65*)

doctor in addition to any other malpractice insurance the hospital may be carrying. In any event, the hospital should make sure it is adequately covered against liability."

6. Arrangements for transfer of radiology and pathology services from Blue Cross to Blue Shield, as required by law, had not yet been completed, Mr. Johnson reported. "It is therefore suggested that no contract be made on any permanent basis until it is determined what the relationship between Blue Cross and Blue Shield in the providing of coverage of these services turns out to be," he added.

7. Financial arrangements with pathologists and radiologists may be percentage arrangements, but other arrangements are also legal, it was explained. Among those suggested were: Minimum or maximum guarantees plus a percentage arrangement; fixed unit cost arrangements; or "any other arrangement which might be mutually agreed upon, so long as it fairly appears that no employer-employe relationship is created."

8. If a percentage arrangement is made, hospitals should take care to spell out what items the percentage is to be applied to, Mr. Johnson warned. "In other words, is it a percentage of gross earnings or receipts, or a percentage of some sum arrived at after the deduction of certain specific items, such as expenses, bad debts, utilities, depreciation, new equipment, or general expenses?" he explained.

In another convention session, J. Douglas Colman, vice president of the Blue Cross Association, predicted that there will be more integration among hospitals and standardization of hospital services and procedures in the future, in response to public demand. Hospitals today are on a stronger financial base than ever before, Mr. Colman said, and hospital revenues are more stable than at any previous time. As evidence that this is the case, he mentioned the fact that loans for hospital construction are regarded today as sound, safe, long-term investments—in contrast to the situation a few years ago, when hospital loans were regarded as highly speculative and unsatisfactory.

"The payment by the various governmental agencies for care of indigents in hospitals on a cost basis is the final step in building a strong foundation under hospital finances," Mr. Colman said.

In addition to Mr. Bondi, other officers elected by the association were: first vice president, James L. Dack, administrator, Methodist Hospital, Sioux City; second vice president, Sister Mary Muriel, administrator, St. Anthony's Hospital, Carroll; treasurer, Stanley Volga, administrator of Myrtue Hospital, Harlan. Lloyd W. Coe, Des Moines, was reelected executive secretary of the association.

Elected to the board of trustees were J. W. Myers, administrator, Muscatine County Hospital, Muscatine, and Charles Patterson, Sioux City.

Costs Will Continue to Rise, Crosby Tells Southeasterners

(*Continued From Page* 70)

the patient is likely to be high, Mr. Brown warned.

5. On the other hand, rates should discourage over-use of hospital facilities. This was the trouble with the inclusive rate system of grouping charges, Mr. Brown said. "What is needed is a proper balance between encouraging necessary use of facilities and discouraging unnecessary use," he said.

6. The rates should minimize accounting and collection expense. Trivial charges may cost more to set up and collect than the revenue warrants, Mr. Brown pointed out. "Our general rule is that an item all patients are likely to get, such as aspirin or sedatives, should be put on the room charge and not charged separately," he explained.

7. The rate structure should encourage the best means of distributing medical and hospital care and not destroy the system. The fact that x-ray charges were generally higher than they should have been was chiefly responsible for the trouble between radiologists and hospitals, and resulted in deterioration of the best system for the public, Mr. Brown explained. "The specialists took over," he said. "In other words, we defeated our own ends by creating exorbitant fee schedules for these services. If there had been no profits, medical ethics would never have been brought into the discussion of hospital-specialist relationships. The doctors would have begged us to hold on to these services."

Finally, Mr. Brown said, the individual hospital's own situation must be taken into consideration in determining rates. Thus Rhode Island, with 80 per cent of the population enrolled in Blue Cross, would be expected to have a different rate structure from Illinois, with only 20 per cent. "The hospital's situation is the most important single consideration in rate making," he concluded.

At another session, Blue Cross was the target of a critical blast from E. C. Bramlett, assistant administrator of the Mobile Infirmary at Mobile, Ala. Blue Cross is creating rather than solving problems for hospitals, Mr. Bramlett charged. The service concept in Blue Cross encourages over-utilization of hospital facilities, with resulting loss to hospitals which are required to discount Blue Cross bills, he said.

Mr. Bramlett also objected to the need for guaranteeing groups of hospital employes, to the lack of disaster coverage in Blue Cross, and to the building of reserve funds in Blue Cross plans—"when hospitals do the underwriting," he added.

Commercial insurance on an indemnity basis, with co-insurance features to deter unnecessary use of services, is better for the public and hospitals, Mr. Bramlett concluded.

In a scheduled rebuttal to these charges, Richard C. Williams, executive director of Mississippi Hospital and Medical Service, denied that insurance plans meet the needs of the public better than Blue Cross, or that hospitals are better off with patients who have insurance.

"The patient with insurance may turn out not to have coverage after you have admitted him," he pointed out. "Losses to hospitals for this reason are probably ten times what they are for the same cause in Blue Cross."

Furthermore, Mr. Williams added, hospitals are represented on the boards of Blue Cross plans and have been consulted throughout the development of the Blue Cross movement. "How many people here are on the board of directors

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of an insurance company?" he asked.

At the annual business meeting of the Southeastern Hospital Conference, Robert Ivy, Doster Hospital, Columbus, Miss., was named president-elect of the association for the coming year. He will succeed Pat Groner, Baptist Hospital, Pensacola, Fla., who became president during the convention, succeeding R. E. Blue, Willis Knighton Memorial Hospital, Shreveport, La.

Other officers elected by the conference are: vice president, Oscar S. Hillard, Tri-County Hospital, Fort Oglethorpe, Ga.; directors: J. Frank Bynum, Gibson Hospital, Enterprise, Ala.; Ben P. Wilson, Munroe Memorial Hospital, Ocala, Fla.; W. H. Hunt, University Hospital, Augusta, Ga.; Dr. John C. Mackenzie, Touro Infirmary, New Orleans; Harry C. Cutler, Riley Hospital, Meridian, Miss.; John Tallmadge, Fort Sanders Presbyterian Hospital, Knoxville, Tenn.; Frank Magoffin, Oakville Sanatorium, Memphis, Tenn., and R. E. Blue of Shreveport, La. Charles W. Flynn is executive secretary-treasurer.

Dr. Mackenzie Installed as Louisiana President

SHREVEPORT, LA. — Dr. John C. Mackenzie, director of Touro Infirmary, New Orleans, was installed as president of the Louisiana Hospital Association during the 32d annual meeting here April 4 to 6, succeeding Herman L. Herold, administrator of North Louisiana Sanitarium, Shreveport.

Freeman E. May, administrator of Baptist Hospital, Alexandria, was named president-elect, and Charles Kasischke, administrator of Southeast Louisiana Hospital, Mandeville, vice president. Charles R. Gage continues as executive secretary-treasurer.

Speaking at the meeting were Dr. Frank Groner, president-elect of the American College of Hospital Administrators, and Tol Terrell, president-elect of the American Hospital Association.

Blue Cross Pays $1 Billion

CHICAGO. — More than $1 billion worth of hospital care went to Blue Cross members in 1956, the Blue Cross Commission has announced. This is the largest amount paid in a single year in the history of hospital prepayment. Some 9 million members admitted to hospitals last year received more than 53 million patient days of care through Blue Cross, the report stated.

Urges State-Level Talks Between Hospitals, Nurses

BELLINGHAM, WASH.—Renewal of discussions between the Washington State Hospital Association and the Washington State Nurses Association concerning agreements between nurses and hospitals at the local or regional level has been urged by the board of trustees of the hospital association. The action took place at the mid-year meeting here in April. A committee was appointed to meet with nurse association representatives.

Until two years ago the two associations had agreed upon recommended wages and working conditions for general duty nurses, which prevailed in the majority of hospitals. The pattern broke down in 1956 when basic salaries and fringe benefits were no longer practicable on a statewide basis because of different economic patterns within the state, W.H.A. officials said. Since that time discussions have been on a local or district basis.

A bill sponsored by the nurses' group to require hospitals to bargain collectively with nurses and other employes died in a committee of the state legislature in March. About 125 persons attended.

ABOUT PEOPLE

(*Continued From Page 78*)


Peter J. Buttaro

Peter J. Buttaro has been appointed executive director of LaCroix Hospital, White Pine, Mich. He formerly held the position of administrative assistant and clinic coordinator of Louis A. Weiss Memorial Hospital, Chicago. Mr. Buttaro is a graduate of the Northwestern University hospital administration course, a nominee of the American College of Hospital Administrators, and a member of the American Hospital Association.

William A. Stoppani has been appointed assistant administrator of Symmes Arlington Hospital, Arlington, Mass. He formerly was the administrator of Woodward Memorial Hospital, Sandwich, Ill., and is a graduate of the Columbia University course in hospital administration.

Sister M. Georgiana has been named administrator of St. Mary's Hospital, Orange, N.J. Prior to this appointment she had been controller at St. Agnes Hospital, White Plains, N.Y., and assistant administrator of St. Francis' Hospital, Port Jervis, N.Y. She succeeds **Sister M. Madeline,** who has not yet been reassigned.

Gaston Herd has been appointed assistant administrator of Fort Hamilton Hospital, Hamilton, Ohio. Mr. Herd has recently been associated with the hospital and medical facilities division, Kentucky Department of Health, and Hardin Memorial Hospital, Elizabethtown, Ky.

Ray Q. Bumgarner, assistant manager of the Veterans Administration Research Hospital in Chicago, has been named manager of the V.A. center in Hot Springs, S.D., succeeding **Paul A. Hatton,** who has retired.

Robert E. Trimble, whose resignation as administrator of Parkview Hospital, El Reno, Okla., was reported in May issue of The MODERN HOSPITAL, has been named house manager of Florida Sanitarium and Hospital, Orlando, Fla.

Charles P. Harris Jr. has been named administrator of Pewee Valley Sanitarium and Hospital, Pewee Valley, Ky., succeeding **Paul C. Dysinger,** who has been appointed general manager of Madison Sanitarium and Hospital, Madison College, Tenn.

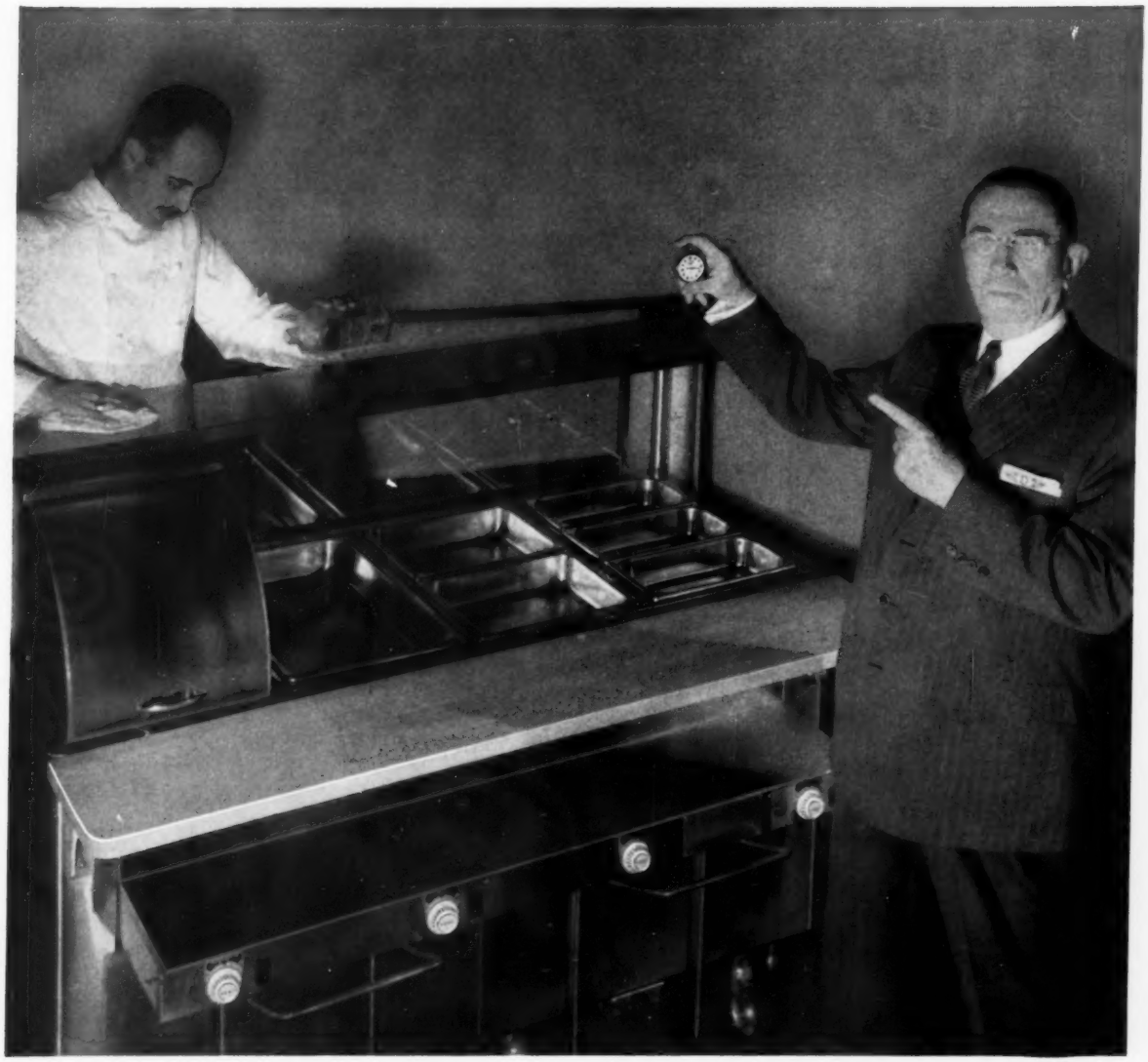

Leslie R. Smith

Leslie R. Smith has been appointed assistant director of Harbor General Hospital, Torrance, Calif. He formerly was senior administrative assistant at Rancho Los Amigos Hospital, Hondo, Calif. Mr. Smith is a graduate of the College of the Pacific and received his master's degree in public administration from the University of Southern California.

Dudley Hall has been named to the newly created post of assistant administrator at Harris Hospital, Fort Worth, Tex. Mr. Hall formerly was administrative assistant at the hospital.

C. R. Peery has been named administrative assistant at Mound Park Hospital, St. Petersburg, Fla. A graduate of the Medical College of Virginia's course in hospital administration, Mr. Peery served his administrative residency at Mound Park Hospital.

Thomas L. Askew has been appointed administrator of King's Daughters' Hospital, Yazoo City, Miss., succeeding **Winston C. Whitfield,** who has resigned to accept a similar position in



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Alabama. Mr. Askew, who has been assistant administrator of Mercy Hospital-Street Memorial, Vicksburg, Miss., is a member of the American College of Hospital Administrators and a graduate of the hospital administration course at Northwestern University.

Department Heads

Lt. Stephen B. Collins has been appointed medical service management analysis officer of the 3750th Air Force Hospital, Sheppard Air Force Base, Wichita Falls, Tex. Lt. Collins is a graduate of the hospital administration course of Washington University and completed a one year residency at Barnes Hospital, St. Louis, before entering the air force.

Janet Mastin has been named director of the dietary department at University Hospital and Hillman Clinic, Birmingham, Ala. In addition to a term of service as therapeutic dietitian of Florida State Hospital in Chattahoochee, Mrs. Mastin has been supervising dietitian and assistant manager of the men's campus food service of Florida State University. She later became assistant manager of the total student center food service at the university.

Alice Tastor, R.N., has been named director of nurses at Rio Hondo Hospital, Rivera, Calif. Prior to her present position, she served several years as director of nurses at Monterey County Hospital, Salinas, Calif.

Dr. Robert R. Brown has been named medical director of Massachusetts Osteopathic Hospital, Boston. A graduate of the Philadelphia College of Osteopathy, Dr. Brown served his internship at the Massachusetts hospital and at one time was associate director of the outpatient department there.

Clarence J. Jupiter has been appointed to the new post of personnel and public relations director at Flint-Goodridge Hospital, New Orleans. He previously was associated with an encyclopedia publishing firm as personnel director.

J. Marion Stewart has been named director of nursing of the City of Hope Medical Center, Duarte, Calif. Miss Stewart, who has been assistant nursing director, succeeds **Constance L. O'Brien.** The new director has held supervisory and instructional positions in nursing in Ohio and California.

Florence Fifield, director of nursing service at Hurley Hospital, Flint, Mich., has resigned for reasons of health. She will accept a similar position in a San Francisco hospital.

Miscellaneous


Hiram Sibley

Hiram Sibley has been appointed secretary of the American Hospital Association's Council on Hospital Planning, it is announced by Dr. Edwin L. Crosby, director. Mr. Sibley has been director of program development for the Yale-New Haven Medical Center since 1954. Previously he served as executive director of the Connecticut Hospital Association. **Helen D. McGuire** has been named assistant secretary of the A.H.A. Council on Professional Practice. Mrs. McGuire has been chief of the medical record branch in the division of hospital of the U.S. Public Health Service since 1949. At the same time Dr. Crosby announced that **Dr. Madison B. Brown,** director of administrative services, has been appointed associate director of the Association.


Dr. Frederick D. Mott

Dr. Frederick D. Mott, director of the Miners Memorial Hospital Association of the United Mine Workers, has resigned to become executive director of the Community Health Association, United Auto Workers health insurance plan in Detroit. His new appointment becomes effective September 1. Dr. Mott will be succeeded as director of the Miners Association by his deputy, **Dr. John Newdorp.**

Warren C. Rasch has been appointed controller of the Blue Cross Association, to be responsible for administration of all financial aspects of the association's operations. Mr. Rasch has served in a similar capacity with the Blue Cross Commission since 1949 and was previously associated with an auditing firm. **Gerald M. Green** has been named regional manager at New York City by the association. Mr. Green first entered the Blue Cross field with the Hospital Service of Southern California in 1946, serving as district manager and director of labor relations. In 1954 he became manager of sales and service of Health Service, Inc., in New York. At the same time it was announced that **J. Douglas Colman** and **Antone Singsen** have exchanged the titles of secretary and treasurer of the association, so that Mr. Colman is now vice president and sec-

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retary while Mr. Singsen is vice president and treasurer.

E. Duncan Millican, president of the Quebec Hospital Service Association in Montreal, has been named to the Blue Cross Commission. He succeeds **F. D. MacCharles,** executive director of the Manitoba Hospital Service Association, Winnipeg, who has resigned from the commission. Mr. Millican will represent Blue Cross Plan District 12, which comprises all of Canada. He previously served in the position from December 1946 to April 1952.

Dr. David F. Stone has been appointed director of the bureau of local health administration of the Indiana State Board of Health. **Dr. Earl H. Hare,** whose retirement as head of the Veterans Administration hospital in Indianapolis was announced in the April issue of The MODERN HOSPITAL, will succeed Dr. Stone as director of the division of tuberculosis control for the state board of health.

William A. Taylor has joined the staff of the bureau of special health services of the Florida State Board of Health as a hospital consultant. Mr. Taylor, who is a graduate of Duke University's program in hospital administration, formerly was assistant administrator of Children's Hospital, Cincinnati, and administrator of Victory Memorial Hospital, Brooklyn, N.Y.

Oscar McDowell Marvin Jr. and his wife, **Jane Krauss Marvin,** have been appointed short-term hospital administrator missionaries to Japan by the Board of World Missions of the Presbyterian Church in the U.S. They will serve at the Yodogawa Christian Hospital in Osaka for three years.

John A. Dare, administrator of Virginia Mason Hospital, Seattle, has been elected president of the Washington Hospital Service Association, the Blue Cross plan for Washington and Alaska, succeeding **Walter A. Heath.** Mr. Dare is immediate past president of the Association of Western Hospitals and a past president of the Washington State Hospital Association.

Sister Olivia Marie, C.S.C., administrator of Holy Cross Hospital in Salt Lake City, Utah, has been elected president of the Intermountain Hospital Service, Blue Cross plan for Utah. She succeeds **John H. Zenger,** administrator of Utah Valley Hospital, Provo.

J. Albert Durgom, vice president of the Hospital Service Plan of New Jersey for the last three years, has been advanced to the post of executive vice president. Mr. Durgom, who is in charge of the plan's enrollment and hospital relations activities, had held the title of executive director since 1937.

Dr. F. Webster McBryde has joined the staff of Gordon A. Friesen Associates, Inc., of Washington, D.C., as director of regional planning. He is in charge of the firm's demographic and socio-economic hospital planning surveys in the Washington, D.C., area and in Latin America. Other appointments announced at the same time were **Margaret D. McLean,** associate professor in nursing education at the University of Western Ontario, who has become director of nursing education and surveys for the firm, and **John Lawrence Ryan Jr.,** assistant administrator of Spohn Hospital, Corpus Christi, Tex., who has been named executive director of the survey in Costa Rica. He will be assisted by **Greta Isabel Wolfe,** associate director of nursing education and surveys, and **Elfriede Thiemann,** associate director of regional planning. **W. Taylor Morrow,** former administrative resident at Southern Baptist Hospital, New Orleans, is now serving as executive assistant for the firm.

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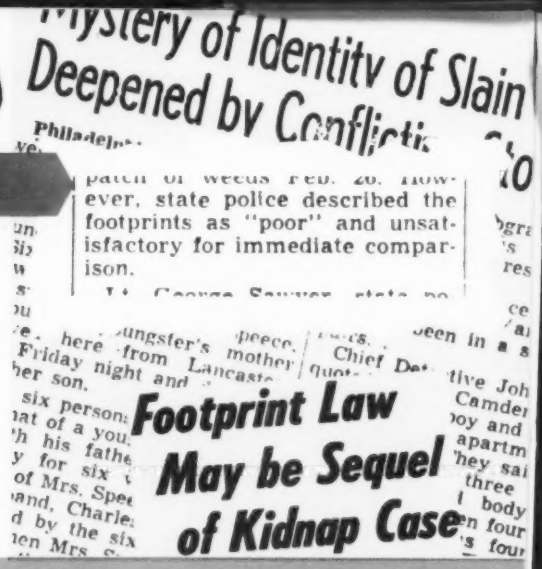

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...patch of weeds Feb. 20. However, state police described the footprints as "poor" and unsatisfactory for immediate comparison.

Footprint Law May be Sequel of Kidnap Case

F. B. I. Law Enforcement Bulletin: "The purpose of taking footprints is to provide a permanent record of individuality so that in the event a question should arise later as to the identity of the child and its mother, conclusive proof of its identity can be offered. The footprints of the infant, therefore, should be taken at birth."

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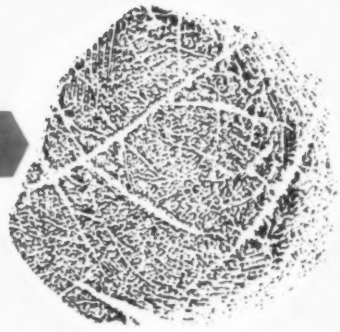

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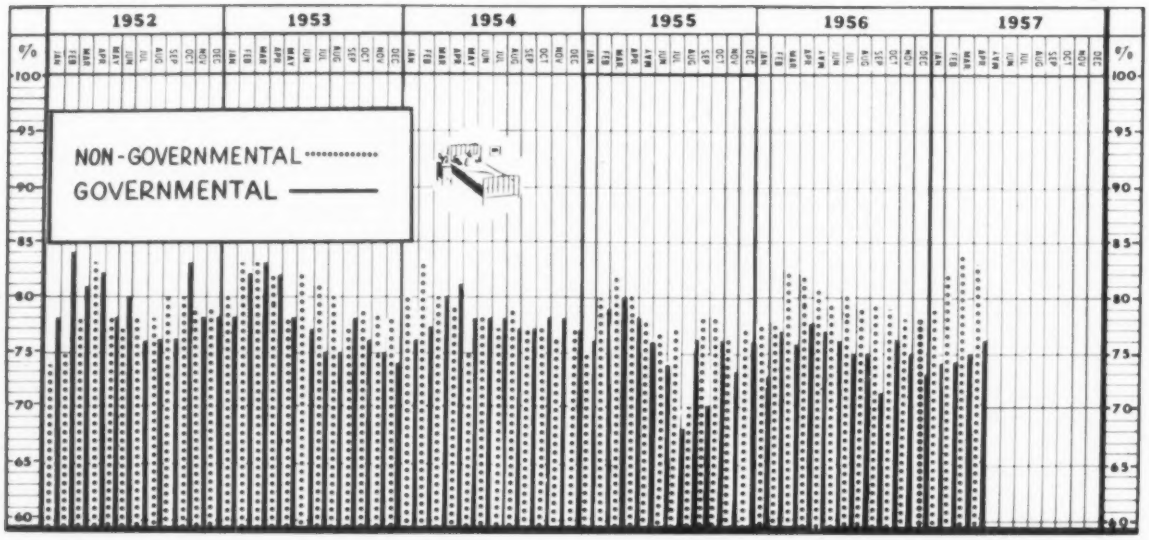
Voluntary Hospital Occupancy Up Over Last Year



Voluntary hospital reports to the Occupancy Chart for the month of April indicate occupancy at 83.3 per cent of capacity—2.4 per cent over the occupancy reported for April 1956. Government hospitals reported 76 per cent—a 0.7 per cent decline from last year's occupancy for April.

From April 15 to May 13, new hospital construction totaled $64,838,700, and brought the year's total thus far to $290,270,770. For the similar period of 1956, building totaled $84,547,210, aggregating $269,610,440 to April 30, 1956. Of the current 75 projects, 16 are hospitals, 51 are additions to existing facilities, four are alteration projects, and four are nurses' homes.

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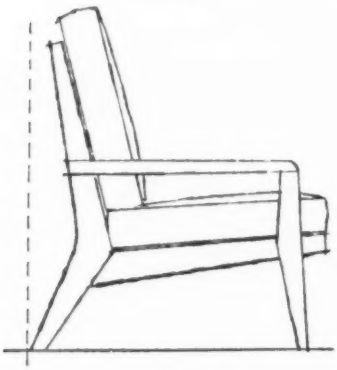

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ADMINISTRATOR—Non-medical; seeking new position midwest; age, under 40 years; experience, 5 years in 150-bed geriatric institution; excellent record; available, January. Apply MW 195, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; seventeen years experience to free lance or percentage basis; consider any location. Apply MW 194, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

CHIEF PHARMACIST & ASSISTANT ADMINISTRATOR — Combination; for 150-200 bed hospital; four years experience as chief pharmacist in a 200-bed hospital; references; prefer Virginia, Tennessee, Carolinas, Alabama, Georgia. Apply MW 193, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Registered record; wants to relocate in small accredited hospital in eastern state. Apply MW 196, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—M.H.A; four years, associate director, teaching hospital, assisting in building program increasing capacity from 200 to 400; six years, director, 225-bed hospital.

ASSISTANT ADMINISTRATOR — M.H.A. (Hospital Administration) administrative resident, teaching hospital; 2 years, assistant administrator, 175-bed hospital.

ADMINISTRATOR—Medical; has had two important administrative assignments since 1940; in both instances performance considered outstanding; highly regarded in the field.

ADMINISTRATOR—Professional nurse; B.S. in Nursing; M.P.H., Hospital Administration; three years, assistant administrator, 400-bed general hospital.

FOOD SUPERVISOR—B.S. (Major: Hotel and Restaurant Management); excellent experience.

MEDICAL BUREAU—*Continued*

PATHOLOGIST—M.S. (Pathology); Diplomate (Pathologic Anatomy; Clinical Pathology); eight years, director, pathology, 250-bed hospital; recently completed military service.

RADIOLOGIST—University hospital training in radiology; graduate training, isotopes; six years, director department, 250-bed hospital; Diplomate.

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ADMINISTRATOR—B.S. (Business Administration), M.S. (Hospital Administration); 5 years, hospital accounting, office and credit manager, 150-bed hospital; 18 months, assistant director, 1000-bed teaching hospital; any locality; early 30's. Nominee ACHA.

ASSISTANT—ADMINISTRATOR—R.N., B.S., M.H.A., 6 years private duty, 5 years, charge nurse and supervisor, Army hospitals; 2 years; director of nurses, large general hospital; well prepared for and interested in hospital administration; prefers southwest; medium sized hospitals.

PATHOLOGIST—Several years, assistant professor and director clinical pathology, university medical school and associate director, 300-bed teaching hospital; middle 30's; Diplomate, clinical, anatomy.

RADIOLOGIST—Mayo trained; M.S., radiology; 4 years, chief, 600-bed medical school affiliated hospital; Diplomate, both branches isotopes.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—Degree, Business Administration; male nurses; 12 years personnel supervisor—business consultant. 2 years administrator, small hospital.

BUSINESS MANAGER—Or assistant administrator; 10 years accounting and business manager, 250-bed hospital; excellent references.

ASSISTANT ADMINISTRATOR—Or purchasing agent; M.S.H.A. degrees; resident, 300-bed hospital, east; past 3 years administrative assistant.

ADMINISTRATOR—R.N. B.S. Degree, western university, director of nursing, 3 years, 100-bed Nebraska hospital; 2 years nurse executive.

PUBLIC RELATIONS DIRECTOR — Young business woman; B.A. Degree; diversified experience, including personnel management, large teaching center.

EXECUTIVE HOUSEKEEPER — 2 years College; 12 years housekeeper, 200-bed eastern hospital.

(Continued on page 198)

POSITIONS OPEN

ADMINISTRATOR—For 300-bed modern general hospital located in northern Illinois; applicant must have several years successful experience in similar post, including the planning of new facilities, methods improvement, cost reduction, personnel and public relations. Applications may be submitted in strict confidence through E. R. Perrin, 19th Floor, 8 South Michigan Avenue, Chicago, acting as mediary for Hospital Board.

ADMINISTRATOR—Assistant; female R.N; in charge nursing service, nurse aide program, drugs & supplies; relief of administrator; suggest $400.00 salary but varying with qualifications; maintenance can be furnished; position open June 1, an interview desirable. Apply Administrator, Murphy Memorial Hospital, 1201 Highland Avenue, Red Oak, Iowa.

ADMINISTRATOR or BUSINESS MANAGER —For small general hospital near Milwaukee area; salary open; only experienced considered. Apply MO 199, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHESIOLOGIST—400-bed general hospital, located in mid-west desires an anesthesiologist to assume some administrative duties and be available for anesthetics. Apply MO 191, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST — Nurse; for 400-bed Joint Commission Accredited hospital; salary $460 per month, 40 hour week; opportunity for paid overtime work; many employee benefits. Apply Dr. R. Weyl, Anesthesiologist, Mount Sinai Hospital, Chicago 8, Illinois.

ANESTHETIST—Registered nurse for obstetrics; salary open, three weeks vacation the first year, 12 days sick leave per year, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETIST—Nurse; position open in 134-bed general hospital; salary and living conditions very desirable; room, laundry and insurance benefits furnished in addition to salary; location on the east side of St. Paul with convenient transportation to the downtown area; two other anesthetists on duty with a minimum amount of call. Write E. M. Garnett, Superintendent, Mounds Park Hospital, 200 Earl Street, St. Paul 6, Minnesota.

ANESTHETIST—Nurse; immediate opening for 4 anesthetists to complete staff of 12 for modern 382-bed general hospital with air-conditioned surgery; salary commensurate with ability. Apply John M. Willis, M.D., Director, Hamot Hospital, Erie, Pa.

ANESTHETIST—Nurse; for 109-bed hospital; two anesthetists with extra relief anesthetist; no ob. call; alternate weekends off, week day off in alternate weeks. Contact: Mrs. J. E. Lindsey, Administrator, Retreat for the Sick, 2621 Grove Avenue, Richmond, Virginia.

ANESTHETISTS — Nurse; AANA members; $400-$475 per month, 400-bed general hospital, excellent working conditions, liberal personnel policies; T.O., 16 anesthetists and one anesthesiologist. Write Personnel Director, The Queen's Hospital, Honolulu, Hawaii.

classified advertising

POSITIONS OPEN

ASSISTANT DIRECTOR NURSING SERVICE—115-bed general hospital expanding to 242-beds in Chicago suburb; no nursing school; approved J.C.A.H. Degree and nursing administrative experience required; 4 weeks annual vacation, good personnel policies; salary open. Apply Director Nursing Service, Ingalls Memorial Hospital, Harvey, Illinois.

ASSOCIATE DIRECTOR—635-bed medical center nursing school, 3 year diploma program, no affiliations; Master's degree; salary excellent. Write Director, Albany Medical Center, School of Nursing, Albany, New York.

DIETITIAN—A.D.A., B.S. degree and experience required; 5 day week, 4 weeks vacation, 2 weeks sick leave, 6½ holidays, social security, group insurance; 275-bed hospital in college town midway between Detroit and Chicago; salary open. Apply MO 181, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—110-beds; complete charge of food service, menu planning and buying, personnel management and patient contact; salary open. Apply MO 194, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Assistant; Tucson, Arizona; 150-bed county hospital. Apply to Administrator Pima County Hospital, Tucson, Arizona.

DIETITIAN—Administrative; for food production and distribution in 400-bed general community hospital with 100-bed pediatric unit; early advancement to more responsible position possible for right person; 40 hour work week, liberal benefits; salary commensurate with experience and responsibility. Apply Personnel Department, Iowa Methodist Hospital, Des Moines, Iowa.

DIETITIAN—Therapeutic; A.D.A. member, for 160-bed general hospital; good personnel practices. Apply Frederick Memorial Hospital, Frederick, Maryland.

DIETITIAN—Administrative; Borgess Hospital, 340-bed general hospital; full department head duties; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIAN—Head; 250-bed geriatrics hospital, resort area near Detroit; 33 person food staff. Apply Personnel Office, Oakland County Office Building, 1 Lafayette, Pontiac, Michigan.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Assistant; preferably with therapeutic experience and considerable experience in personnel management; salary open; 40-hour week, liberal fringe benefits, position immediately available; hospital located in heart of beautiful Niagara County, New York—about 20 miles north of Buffalo and 18 miles east of Niagara Falls. For full information write Miss Betty Hall, Chief Dietitian, Lockport Memorial Hospital, Lockport, New York.

DIETITIAN—First assistant; new position; residential city near Cleveland; general hospital of 117-beds, expanding to 170-beds; beginning in 1958, further expansion of 150-beds on a separate site; residence available. Apply Lake County Memorial Hospital, Painesville, Ohio.

(Continued on page 200)

NEW *Ideal* MEALMOBILE with...

MECHANICALLY REFRIGERATED COLD SECTION with Built-In BEVERAGE DISPENSER

The cold section of the new IDEAL Mealmobile gives you a refrigerator on wheels . . . eliminates the problem of handling and freezing dole plates. A unique blower arrangement maintains an even temperature, selected by thermostat, throughout the cold compartment.

The IDEAL Model 9020 BCT delivers with "kitchen control" 20 meals of hot and cold foods and dispenses both hot and cold liquids. This new IDEAL Mealmobile is truly a new plus in food serving efficiency!

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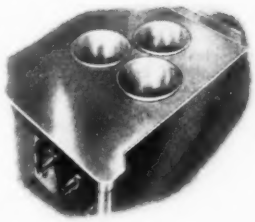
Eliminates dirt catching crevices. Open corners permit easy cleaning. Extended edge of guard prevents articles carried on top deck from sliding off in transit.



BEVERAGE DISPENSER

Exclusive Ideal built-in beverage dispensers feature individual thermostatic control. Thoroughly insulated from each other and from the remainder of the cart, they can carry both hot and cold liquids. Each well has 5½ quart capacity.

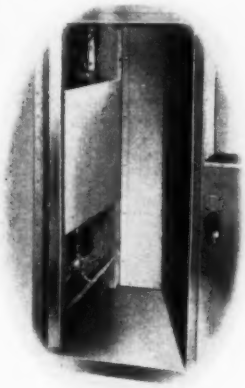
REFRIGERANT COMPRESSOR

The ¼ H.P. refrigerant compressor is protected by a 20 ga. stainless steel housing. Thermostat on compressor housing permits selection of cold compartment temperature. Switch permits blower in cold compartment to be turned off when doors to cold section are open.

Model 9020BCT

LOCK SEAMED INSULATED DOORS

Exclusive Ideal overlapping doors provide positive seal regardless of temperature extremes. Easy to open and close. Glass fiber insulation reduces temperature change inside compartments.



NO-TIP TRAY GUIDES

Exclusive "no-tip" guides allow tray to be pulled out all the way and kept level for drawer-to-tray serving without lifting tray to top deck. Affords speedier service and less chance for error.

SUPER SIZE DRAWERS

Seven heavy gauge aluminum drawers in the heated section. Each holds three 9" plates plus three side serving dishes. Safety stops and name card holders.

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A unique blower-coil arrangement keeps temperature within the cold compartment even throughout. Drip trough and cup catch water resulting from condensation . . . eliminate puddles on bottom of cold section.

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POSITIONS OPEN

DIETITIAN — A.D.A., therapeutic; 160-bed general hospital, college town, 20 miles west of Milwaukee; major expansion program to be started in spring of 1957; modern dietary department completely remodeled in 1954-55. Apply Personnel Department, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF NURSING SERVICE—243-bed general hospital, fully approved; school of nursing, intern and resident program; degree preferred; liberal personnel policies, including 40 hour week; salary open, based on preparation and experience; expenses paid for personal interview. Send detailed resume of training and experience to Personnel Office, St. Joseph Hospital, Lexington, Kentucky.

ASSOCIATE DIRECTOR OF NURSING SERVICE—Responsible for nursing service in 300-bed nonprofit hospital, Los Angeles Metropolitan area; prefer candidate with preparation and/or experience in nursing service administration; salary based on qualifications: 40 hour week, Blue Cross-Blue Shield insurance available; 21 days vacation, 6 paid holidays, sick leave; live in if desired. Write to MO 193, The Modern Hospital, 919 North Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—To replace retiring director in 190-bed general community hospital located in resort city of 50,000 on Lake Michigan; hospital fully accredited by Joint Commission; A.M.A. approved programs for interns, lab technicians and x-ray technicians; school of nursing; written personnel policies, liberal benefits, starting salary $6500. per annum; degree desired; not required. Apply MO 198, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois. State experience and qualifications.

DIRECTOR OF NURSES—100-bed hospital now being enlarged to 180-beds; adequate training and experience required; salary open. Apply Administrator, Municipal Hospital, Virginia, Minnesota.

DIRECTOR OF NURSING EDUCATION—Man or woman; J.C.A.H. approved; 220-beds; B.S. in Education, Masters preferred; experience; liberal personnel policies; salary open with meals; diploma program; also nursing arts instructor, B.S. or working toward it. Write Director of Nursing, P.O. Box 529, Orangeburg, South Carolina.

DIRECTOR—Personnel; large hospital research center; 1,000 employees; good salary and working relations; organize new program; experience required. Write MO 187, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF VOLUNTEER PROGRAM—For 230-bed general hospital; excellent opportunity for mature professional women with experience in hospital administration or nursing service to initiate and implement expanding volunteer program; liberal personnel policies; excellent maintenance available at minimum charge; salary open. Apply Administrator, United Hospital, Boston Post Road, Port Chester, New York.

EDUCATIONAL DIRECTOR—Position open now; Master's degree preferred; Roman Catholic preferred; would like person with experience in the new type diploma or college degree programs; salary $4800 to $6000, depending on experience and qualification; midwest location. Apply MO 189, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

EDUCATIONAL DIRECTOR—Masters Degree and experience in teaching desirable; salary open, liberal personnel policies including 40 hour week, all cash salary, pension plan in addition to social security and hospitalization; living quarters available if desired; admit one class a year; three year diploma program; 300-bed hospital, 89 students; basic sciences taught at New Jersey Teacher's College; position open May 1957. Apply to Director of Nursing, The Mercer Hospital, Trenton, New Jersey.

HOUSEKEEPER—Executive; supervise 40-50 employees; 340-bed general hospital, large expansion and remodeling program just completed; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

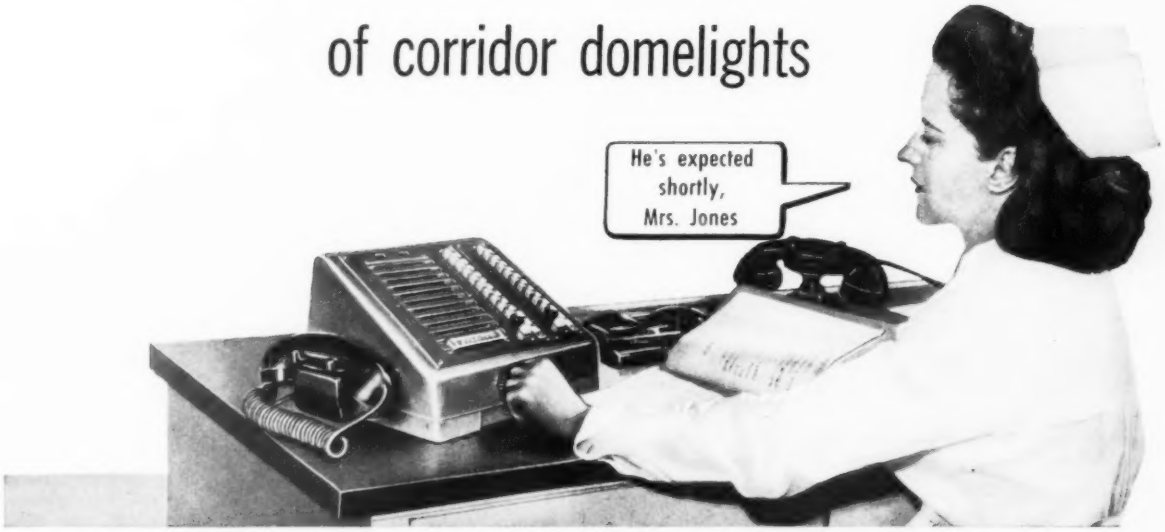
(Continued on page 202)

Add **AUDIO** easily

to your present

VISUAL nurse call system

of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

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How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

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POSITIONS OPEN

CLINICAL instructure in medical and surgical nursing; approved school of 50 students; all approved policies; B.A. required; M.A. desired. Write Director of Nursing, Danbury Hospital, Danbury, Connecticut.

INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Psychiatric nursing; B.S. Degree required; $3300 yearly salary; furnished apartment, meals and laundry, 40 hour, 5 day week, paid vacation, 7 holidays and liberal sick leave; approximate starting date April 15. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Clinical; in obstetrical nursing for both formal and clinical teaching; B.S. Degree and experience in teaching desirable; faculty being increased; liberal personnel policies; salary dependent upon qualifications and experience; admit one class a year, three year diploma program; 300-bed hospital, 89 students, position open for immediate appointment. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Nursing Arts; B.S. Degree and experience in teaching desirable; salary dependent upon background and experience; liberal personnel policies; admit one class a year; three year diploma program; 300-bed hospital, 89 students; position open; have full time assistant instructor in this area. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Mental hospital nurse; Central State Hospital, Petersburg, Virginia; starting salary $4512 per year, 40 hour week; must have completed a standard college course with major studies in nursing education, plus one year of experience; must be registered in the state. Apply to Personnel Office, Central State Hospital, Box 271, Petersburg, Virginia.

LIBRARIAN—Registered medical record; to head department in new Teaching Hospital located in midwest college town; 200-beds at present but with facilities to expand to over 400-beds. In reply state training, experience, and salary desired. Apply MO 188, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Registered medical records; To head department; also, opening for assistant to chief department, in accredited hospital of 296-beds and 36 bassinets; 40 hour week and salary open. Apply to Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

MISCELLANEOUS—Wanted Biochemist, also Laboratory Technologist; 250-bed hospital; salaries open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Nurses; Operating Room, Clinical Instructor and Staff Nurses; for teaching hospital within walking distance of Columbia University; salaries and personnel policies comparable to other hospitals in area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, New York.

MISCELLANEOUS—Wanted for 110-bed general hospital: Night supervisor; OR supervisor; average 90 cases monthly; General duty for 3-11 and 11-7 shifts, medical, surgical and obstetrical units; 40 hour week, bonus for Saturday, Sunday and holidays; paid vacations; low cost cafeteria; live out; salaries comparable to area. Contact Director of Nursing Service, The City Hospital, Bellaire, Ohio.

MISCELLANEOUS—Central State Hospital, Petersburg, Virginia; General duty nurses, salary $3024 per year; Head nurses, $3312; Nurse supervisors, $3744; for work in a mental hospital, 40 hour work week; living quarters available; experience preferred but not necessary for general duty nurses; must be registered in the state. Apply Personnel Office, Central State Hospital, Box 271, Petersburg, Virginia.

(Continued on page 204)

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VERSATILITY . . . Sturdy, storable and disposable, these Sealkraft bottles are outstanding in their value as specimen-bottles and other types of laboratory work.

HISTORY . . . these plastic-coated laboratory containers are imprinted on the side to facilitate immediate notemaking . . . these will insure future accuracy of laboratory work.

Just ask your Nurses... *they prefer one-service containers*

NURSING carries enough heavy responsibilities without imposing extra duress. Using disposable paper containers sharply reduces the danger of contagion or cross infections on busy floors . . . lifts one more worry from the nurses' load.

And especially during the night, disposable containers eliminates much onerous, time consuming housework normally done by non-professional people. Yes! your nurses prefer one-service containers and you'll appreciate the fact that you can get them from one source . . . Sealright.

ACCURACY . . . paper measure cups are imprinted on the side for accurate medicinal dosage . . . partially translucent, they are easy, quick to use.

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POSITIONS OPEN

MISCELLANEOUS—Staff, Head Nurse and Supervisory positions; staff and head nurse positions in all clinical areas including psychiatry, tuberculosis and respiratory center; assistant directors of nursing service, evening and night, and second assistant day assignment in new 800-bed, air conditioned hospital; 40 hour week; 3 weeks vacation annually; beginning salary, staff nurses, $275; head nurses, $325 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—General duty and operating room; 100-bed general hospital in Maine; salary $51.20 to $54.40 per 37½ hour week; two meals and laundry allowed; three weeks vacation, sick leave, six holidays. Apply MO 197, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—General duty; interesting work and environment, salary and quarters excellent. Write Maynard MacDougall Memorial Hospital, Nome, Alaska.

NURSES—General duty; for modern 35-bed hospital situated on beautiful South Shore; good personnel policies; excellent living quarters Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

NURSE—Head; new central supply unit; experience and organizational ability required; 5 day week, 2 weeks vacation, 2 weeks sick leave, social security, group insurance, 6½ holidays; 275-bed hospital in college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 182, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSE—Licensed practical or registered; for Old Peoples Home; 40 hour week; pleasant surroundings. Apply MO 195, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for all shifts in new 27-bed unit in general hospital of 275-beds; experience required; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 183, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

(Continued on page 206)

NURSE—Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered staff; in 45-bed pediatric unit; all shifts; 5 day week; liberal policies; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 184, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered staff medical and surgical; all shifts, 5 day week, 2 weeks vacation, 2 weeks sick leave, 6½ holidays, social security and group insurance; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 185, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; for general duty; must have obstetrical experience; surgical experience desirable; salary $325.00 monthly for 40 hour week, with differential for evenings; 44 and 48 hour work available with commensurate pay; 2 week yearly vacation; sick time; new small hospital in mining town; low rental housing units, unfurnished; employment for husband usually available; excellent school; altitude 4000 feet. Write Administrator, Bagdad Hospital, Bagdad, Arizona.

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POSITIONS OPEN

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Registered; are you looking for something new? Staff and assistant head Nurse positions open in beautiful new University of Oregon Medical School Hospital located on hill overlooking Portland, Oregon; medical surgical, pediatric and psychiatric units; excellent opportunities for learning, both in clinical areas and on campus; staff members may take courses at reduced tuition rate ($3 per quarter hour) leading to baccalaureate or masters degrees at the nursing school on the campus; liberal personnel policies; the northwest is a wonderful place to live and work. Write to Director of Nursing Service for full information. U. of O. Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

NURSES — Registered; immediate openings; starting salary $240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES — Registered; psychiatric hospital; liberal personnel policies; 40-hour week, attractive residence; positions available on all shifts; differential salary for evening and night service. Inquire Director of Nurses, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

NURSES—Registered; Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage; salary $4440.00 to $6420.-00, depending on degree of qualification; here is your chance to answer a challenge and to grow with it. For full details send your name and address to Miners Memorial Hospital Association, Box No. 61, 110 Logan Street, Williamson, West Virginia.

NURSE—Registered; for 36-bed hospital; starting salary $205 per month; Blue Cross benefits, sick leave, etc. Apply Superintendent of Nurses, Hospital District No. 24, Box 330, Altona, Manitoba.

NURSES—Registered; for general duty for 150-bed tuberculosis sanatorium in Bartlett, Alaska; starting salary $353 per month with a $10 raise each six months to a maximum base pay of $383; $10 extra for evening and night shift; 8 hour day, 40 hour week, 8 to 4, 4 to 12, 12 to 8 shifts; complete maintenance available for nominal sum; new modern nurses residence; also opening for night supervisor. Write to Director of Nurses, Seward Sanatorium, Bartlett, Alaska.

NURSING — Staff; annually $3000 to $3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area; 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Brandenton, Florida.

NURSE—Surgical; with administrative experience and ability to perform surgery duties in small general hospital on part time basis and function as superintendent of nurses; dual functions provide interest and exercise of judgment and initiative; a real challenge; salary open; hospital is in Central Valley of California, two hours from San Francisco, and one hour from the mountains; pleasant community of 7,000. If interested, write to Administrator, Lillian Collins Hospital, Turlock, California.

(Continued on page 208)

classified advertising

POSITIONS OPEN

PHARMACIST—Staff; 650-bed teaching hospital. Write I. T. Reamer, Chief Pharmacist, Duke University Hospital, Durham, North Carolina.

PHYSICAL THERAPIST—340-bed general hospital; physical therapy department recently moved into new and enlarged quarters; staff therapist, needed; salary open, progressive personnel policies. Apply Personnel Director, Borgess Hospital, Kalamazoo, Mich.

SUPERINTENDENTS—Hospital: Two 122-bed, general, acute-care hospitals located in the metropolitan Detroit area; college degree or its equivalent with five years hospital administration experience required; salary range $9,600 to $15,000. Reply in writing to K. W. Gremore, Executive Director, Peoples Community Hospital Authority, 3030 Wayne Road, Wayne, Michigan.

SUPERVISORS — Outstanding opportunities for qualified supervisors in obstetric and psychiatry and clinical supervisors; 400-bed hospital, approved intern-resident program; school of nursing accredited; excellent beginning salary, pension plan, group life insurance, four weeks vacation. Apply Personnel Director, Christ Hospital, Cincinnati, Ohio.

SUPERVISOR—O.B.; immediate opening; Degree or Post-Graduate; will be employed as floor supervisor and clinical instructor; salary open; 210-bed hospital; good personnel policies; city of over 60,000: Write or call collect Director of Personnel, Sioux Valley Hospital, Sioux Falls, South Dakota.

TECHNICIAN—Laboratory and X-ray; male or female; A.S.C.P. required; salary open, 40 to 48 hour week as desired; 2 week yearly vacation, sick leave; new small hospital in mining town; altitude 4000 feet; low rental housing units, unfurnished; employment for spouse usually available elsewhere in vicinity; excellent school. Write Administrator, Bagdad Hospital, Bagdad, Arizona, stating salary desired.

TECHNOLOGIST—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

TECHNOLOGISTS—Medical; (2); modern expanding Cumberland Valley Hospital; fully approved; college town; 40 hour week, 10 days sick leave, social security, 2 weeks vacation, congenial relationships; maintenance if desired; automatic annual increments; start $3720 per year. Apply F. J. O'Brien, Administrator, Chambersburg Hospital, Chambersburg, Pennsylvania.

TECHNOLOGIST—Laboratory; for a 250-bed hospital in a city of 60,000 population located on Lake Erie; salary open. For details write Pathologist, St. Joseph Hospital, Lorain, Ohio.

ADMINISTRATORS—(a) 200-bed voluntary hospital; superior facility; prefer degree'd man, ACHA affiliation; large city, university medical center; midwest. (b) 120-bed hospital; $8,000; should have hospital degree or excellent experience; east. (c) Medical administrator; chief of clinical services; one with considerable teaching experience, also administrator of teaching; should be certified in a clinical specialty; 590-bed hospital, $13,300, increases; California. (d) Medical; Hebrew; 350-bed voluntary hospital; about 18,000; midwest. (e) Replace administrator retiring after long tenure; 200-bed JCAH hospital; college town, 25,000; on Great Lakes; midwest. (f) Voluntary hospital, 200-beds; fully approved; teaching program; $20,000; West Coast.

(Continued on page 209)

FRANKFORT, GERMANY. BY HOWARD MANDEL

In Germany, too, Pentothal grows in favor . . .

reflecting . . . a world literature unique in modern intravenous anesthesia

A high degree of safety and convenience are but two of the many advantages that have made Pentothal Sodium the world's most widely used intravenous anesthetic. *No other agent has been studied so thoroughly—over 2500 published reports—for such an extended period of time—23 years.* These are solid reasons for your continuing trust in Pentothal Sodium as an agent of choice in the administration of intravenous anesthesia. Abbott

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POSITIONS OPEN

WOODWARD—*Continued*

ASSISTANT ADMINISTRATORS—(a) Assistant; very large teaching hospital; requires MHA; $7,000; east. (b) Children's hospital, very large size; opportunity assume directorship, several years; university city. (c) MHA degree; assistant administrator, 120-bed modern hospital; near Chicago. (d) Assistant administrator; 400-bed medical school affiliated hospital; $7500-$8,000 to start; midwest. (e) Assistant; voluntary hospital, 225-beds; teaching program; about $8,000; large city on Lake Michigan. (f) 200-bed fully approved general hospital; $5,700-$6,700; civil service; New England.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATORS—(a) Medical director qualified re-organize medical staff and direct it; voluntary general hospital, 700-beds; university city, east. (b) Young physician interested in administrative medicine to serve as

MEDICAL BUREAU—*Continued*

assistant medical director, 900-bed general hospital; formal training not required; university medical center, midwest. (c) Director of professional services, voluntary general hospital, 450-beds; preferably man, 35-45, degree, considerable experience; $12,000; east. (d) Director, voluntary general hospital, 200-beds; building program will increase to 300; college town, midwest. (e) Administrator, 85-bed general hospital; degree several years' experience required; California. (f) Assistant; new 250-bed general hospital; university city, south (g) Assistant; 400-bed general hospital; extensive building program; university city, midwest. (h) New 30-bed hospital; vacation land, Minnesota; $6-$7200; woman required. (i) Children's rehabilitation center; university city, east; woman preferred. MH6-1.

ANESTHETISTS—(a) Anesthetist—administrator, new modern 25-bed hospital; vacation resort area; Minnesota; $7200. (b) Staff; nine in department; latest equipment; 200-beds; Detroit; to $7500. (c) Two; opportunity work active hospital heart surgery research team; Florida coastal city; $5400-$6000. (d) Free lance; two active hospitals; college town; relief anesthetist available; great potential; midwest. MH6-2.

DIETITIANS—(a) Chief; brand new medical, surgical hospital opens September; midwest; to $6600. (b) Traveling field dietitian; hospital relief and operational assignments; eastern, southern states; $5200 plus expenses. MH6-3.

(Continued on page 210)

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSING—(a) Director of nurses; private hospital, university affiliation; all-graduate staff; ideal Florida location; $6000; also assistant, $4500. (b) Director, school and nursing service; 600-bed hospital; 100 students; $7-$10,000; east. (c) Director, nursing service; 450-bed university affiliated hospital; strong executive ability required for 2 year expansion; top salary; most desirable West Coast city. (d) Assistant director, outside United States; excellent opportunity utilize executive ability, leading general hospital; English-speaking staff; mild climate; $6-7000. MH6-4.

EXECUTIVE HOUSEKEEPERS—(a) Large general hospital; most renowned resort area, Florida; top salary. (b) Head, department with two assistants; 300-bed hospital, vacation-land near Mexican border. MH6-5.

EXECUTIVE PERSONNEL—(a) Business manager with strong background in accounting; 400-bed hospital; affiliated medical school; midwest. (b) Business manager; 250-bed hospital; university town, southwest. (c) Food service director, 2500-bed hospital, south. (d) Chief engineer, complete charge all maintenance; 250-bed hospital; midwest. (e) Purchasing director; 350-bed general hospital; Master's in Hospital Administration desired, not required; college town, midwest. (f) Personnel director; 300-bed general hospital; college town, Pennsylvania. (g) Director, personnel, public relations; 550-bed hospital, 850 employes; east. MH6-6.

FACULTY POSTS—(a) Foreign assignment; instruct, fundamentals of nursing, 300-bed air-conditioned American owned hospital; $8800, air transportation. (b) Pediatric instructor; responsible for affiliating students; conduct conferences, university appointment, $5000, northwest. (c) Science instructor, teach physi-

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ology, microbiology, chemistry: 150 students; $5600; midwest. (d) Educational director; plan, integrate program; 200 students noted general hospital, 800-beds; university medical center; $8000; midwest; also instructor, medicine, psychology, obstetrics; $5000. MH6-7.

MEDICAL RECORD LIBRARIANS—(a) Chief; organize department; 150-bed medical-surgical hospital opens September; $5600; beautiful suburb, leading city, midwest. (b) Chief; large university teaching hospital; ideal Florida vacation land; $5500. MH6-8.

STAFF NURSES—Foreign assignment; outstanding American company; air-conditioned hospital, living quarters; employ golf, tennis, swimming; $7800, air travel. MH6-9.

SUPERVISORS—(a) Assist teaching board of education sponsored practical nurse program; 5 days; $400-$700. (b) Central supply; organize department, 300-bed new hospital, commuting distance New York City; top salary. (c) Obstetrics; outside United States, well renowned large American hospital; internationally recognized tropical resort; $5500. (d) Ready assume responsibility director nursing service, 40-bed new air-conditioned hospital on Mexican border; $5000 up. (e) Operating room; new 200-bed general hospital; $6400 increasing to $7000; south. MH6-10.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director

332 Bulkley Building

Cleveland, Ohio

ADMINISTRATOR — (a) Small western hospital. (b) 100-bed specialized hospital, east. (c) R.N.; assistant superintendent; 50-bed hospital, Iowa. (d) R.N.; assistant; Orthopedic hospital.

CHIEF ACCOUNTANT — (a) New 250-bed hospital; central state. (b) 150-bed Ohio hospital. (c) 300-bed hospital, mid-west. (d) 200-bed hospital, West Virginia. (e) Credit manager, 200-bed hospital, Ohio.

PERSONNEL DIRECTOR—(a) New teaching center; east. (b) 350-bed hospital, New York State. (c) 300-bed hospital, Pennsylvania. (d) 900-bed hospital, MN; chronic patients.

DIRECTOR OF NURSING—(a) 300-bed new hospital, southeast. $8,000. (b) 250-bed hospital, southern Michigan. (c) 200-bed Ohio hospital. (d) Educational directors; to $6500. (e) Social science; science instructors.

CHIEF PHARMACIST—(a) 275-bed hospital, Ohio. (b) 500-bed Michigan hospital; $6,000.

CHIEF RECORD LIBRARIAN—$5,500; southeast. (b) 400-bed Ohio and Pennsylvania hospitals.

INTERSTATE—*Continued*

TECHNICIANS—Laboratory; X-ray; to $5,000.

EXECUTIVE HOUSEKEEPERS—(a) 180-bed Massachusetts hospital. (b) 200-bed hospital, Illinois. (c) 125-bed new hospital, Virginia. (d) 300-bed Sisters hospitals, east, mid-west; south. (e) 235-bed New Jersey hospital.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

55 East Washington Street

Chicago 2, Illinois

ADMINISTRATIVE PERSONNEL—(a) Administrator; west; 225-bed hospital; excellent opportunity for someone who has had good experience as assistant. (b) Assistant; middle west; 300-bed hospital; Degree in H.A. preferred; $8000 minimum; (c) Assistant; 100-bed hospital near Philadelphia; require R.N. (d) Personnel director; middle west; large hospital; reorganize department and set up personnel policies. (e) Personnel director; middle east; 400-bed hospital; will also work on special projects such as, public relations and methods improvement. (f) Comptroller; south; new 250-

(Continued on page 212)

A NEW DIMENSION in therapy regulators

new All parts are precision machined . . . no maintenance problems

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new Exclusive *REGULITE* adjusting cap for error-free flow setting

new Engineered for vertical positioning of humidifier

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Diaphragms are of special stainless steel. Nylon pointed adjusting screw prevents metallic friction. Easy-reading 2" gauges are color-coded with white calibrations (4000 lb. H.P. O_2 gauges for extra safety).

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LIQUI-MED Therapy Regulators are so simple to use, so practical, and have so many new features that they virtually obsolete any equipment you are now using. They are as safe as modern science can make them. Chromium finish is easily cleaned to hospital standards.

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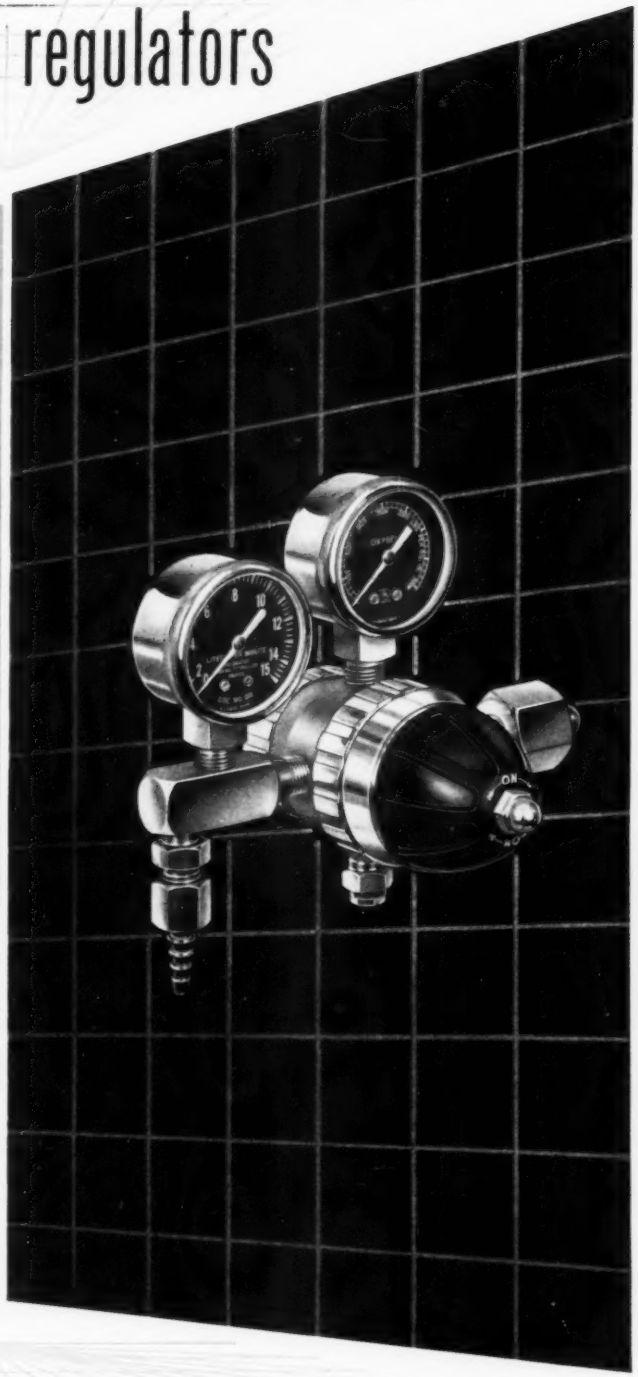

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POSITIONS OPEN

SHAY—*Continued*

bed hospital in city of 75,000; $500-$600. (g) Chief accountant; 250-bed hospital; east; 5 employees in department. $6000 minimum.

EXECUTIVE HOUSEKEEPERS — (a) East; 200-bed hospital in process of expansion; require someone capable of complete reorganizing department. (b) Southeast; new 250-bed hospital; set up department. (c) Middle west; 325-bed hospital in city of 60,000; summer resort area. (d) West; 175-bed hospital in college town; 25 in department. (e) Pacific Northwest. 400-bed hospital; ideal climate year round. (f) Southwest; 300-bed hospital expanding to 600-beds; located in large medical center; $5400 minimum.

NURSE ANESTHETISTS—(a) South; 100-bed hospital; one other anesthetist; $650. (b) California; 250-bed hospital; 4 in department; no O.B.; $510. (c) Hawaii; 200-bed hospital, fully approved; will be reimbursed for transportation; (d) South; 250-bed hospital; 4 anesthesiologists and 5 nurse anesthetists; $550. (e) Middle west; 50-bed hospital in city of 50,000; $500 plus percentage. (f) Southwest; 60-bed hospital in town of 20,000 beautifully located on large lake; 2 in department. $500 up.

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59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS — (a) 350-bed hospital; midwest; metropolitan city; salary open. (b) 400-bed hospital; west; salary open. (c) 100-bed hospital; southwest; $6,000 per annum. (d) 100-bed hospital; Washington; salary $6,000. (e) 25-bed hospital; Texas; $7,200 per annum. (f) 300-bed hospital; New England; salary open. (g) 50-beds; south; $6,000.

ASSISTANT ADMINISTRATORS — (a) RN; Iowa; 50-bed hospital; $450 plus maintenance. (b) 50-bed; northwest; $450. (c) 100-beds; west; $600 per month; experience in construction and engineering helpful. (d) 400-bed hospital; south. (e) 250-bed hospital; south; salary open.

DIRECTOR OF NURSES—(a) New England; salary open; teaching hospital; M.S. Degree; 300-beds; excellent school of nursing; progressive. (b) 400-bed hospital; southwest; school of nursing; M.S. Degree; salary open. (c) Wisconsin, Catholic hospital; excellent school of nursing; salary open. (d) Ohio; 500-bed hospital; excellent school of nursing; M.S. Degree required; salary open.

DIETITIANS—(a) Chief; south; 300-bed hospital; $450 per month; 1 month vacation. (b) Chief; 150-bed hospital; midwest; $400. (c) East; 200-beds; $400.

MEDICAL EMPLOYMENT—*Continued*

RECORDS LIBARIANS—(a) South; 100-beds; salary $400 per month. (b) Midwest; chief; salary $400.

PHARMACISTS—(a) Chief; Ohio; salary open. (b) Chief; California; salary open.

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Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 214)

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Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

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We are pleased to provide confidential service to applicants and employers in the hospital, medical and allied fields. We welcome all inquiries regarding available positions or our well qualified candidates.
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New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

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MISSOURI—18-bed modern hospital. In operation 4 years. County seat town. 100% occupancy 1st quarter 1957. Apply FS 14, The Modern Hospital, 919 North Michigan Avenue, Chicago 11, Illinois.

(Continued on page 216)

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Stevens is known for quality control and unsurpassed values in smoothness, extra whiteness, and durability and the Stevens exclusive Delta Finish®.

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We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduated house. The registration fee is $20. For complete information write to Carolyn Davies R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotrachael intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

MIDWEST HOSPITAL RAISES $1,113,000 OVER GOAL

in two fund-raising campaigns!

1953 Goal: $1,700,000 Raised: $2,500,000

1957 Goal: $ 935,000 Raised: $1,248,000

Back in 1953 the Board of Directors of the Ball Memorial Hospital, Muncie, Indiana, engaged Ketchum, Inc. to direct a campaign to raise $1,700,000 for a new wing for their over-crowded hospital. Result: The campaign exceeded its goal by almost a million dollars.

Again, in 1957, the Board called upon Ketchum, Inc. to direct its $935,000 completion fund drive. At the campaign's "Kick-off" dinner the principal speaker stressed "the importance of getting professional advice in fund-raising efforts, such as that of Ketchum, Inc." When final results were in, the goal was once more exceeded—by more than a quarter of a million dollars. At the victory dinner, Edmund F. Ball, president of the Hospital Board, said: "The professional team (of Ketchum, Inc.) should not be overlooked while I am passing out the bouquets . . . they have been cooperative, competent, and efficient."

It is always a pleasure for Ketchum, Inc. to be welcomed back by a community institution to direct a second campaign. Hospital administrators and Board members are cordially invited to hear about other successful campaigns and discuss their own plans with us at no obligation.

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Work progresses on new facilities of the Ball Memorial Hospital, Muncie, Indiana, now made possible by two campaigns directed by Ketchum, Inc. Objectives have been exceeded by more than a million dollars.

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 256. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Control Syringe Has Interchangeable Parts

An addition to the Multifit line is the new 10 cc. Multifit Luer-Lok Control

Syringe with interchangeable metal parts that fit any 10 cc. Multifit syringe and convert it to a "control" syringe. The necessity for time-consuming repairs is eliminated with this addition to the Multifit line. A new barrel or plunger can be immediately installed at the hospital, using the B-D glass parts in stock.

The interchangeable glass barrels and plungers permit greater ease and speed of assembly since it is unnecessary to match serial numbers. Smaller reserve inventories are needed with the new Multifit Luer-Lok Control Syringe which is now supplied in 10 cc. size and packaged as a complete unit. **Becton, Dickinson & Co., Rutherford, N. J.**

For more details circle #499 on mailing card.

Overhead Door Closer Is Complete Control Unit

The redesigned Rixson concealed overhead type door closer is now a complete door control device. The compact design permits installations on modern, shallow head jambs. In the new unit a hydraulic resistance or back check starts to slow down or check the opening action of the door when it approches 80 degrees. The door can be stopped at any one of four pre-determined factory-set positions.

A built-in door holder holds the door at any one of four positions when specified. The closing speed from open to approximately 15 degrees is regulated by one adjustment as the door closes and the latch speed from 15 degrees to closed position is regulated by another separate adjustment. The redesigned control is available in three sizes for center and butt hung installations. **The Oscar C. Rixson Co., 9100 W. Belmont Ave., Franklin Park, Ill.**

For more details circle #500 on mailing card.

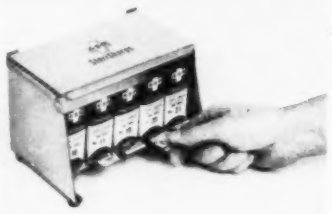
Solution Bottle Has Functional Design

Sure-grip thumb and finger grooves are incorporated into both sides of the new Baxter intravenous solution bottles. The result of a continuous program of improvement in functional design, the new bottles assure safe, easy handling and minimize the danger of breakage by dropping. An improvement in label design incorporates prominent graduations along the edges to complement those molded into the bottle, and 10 cc. graduations in the pediatric series. **Baxter Laboratories, Inc., Morton Grove, Ill.**

For more details circle #501 on mailing card.

Blade Dispenser Facilitates Selection

Selection of the desired size blade is simplified with the new ASR stainless steel blade dispenser now available. The practical unit holds five sizes of packaged stainless steel SteriSharp sterile sur-



gical blades in quantity, immediately available. It is easily filled with the desired sizes and is offered by the blade manufacturer without cost, with special orders. **American Safety Razor Corp., 380 Madison Ave., New York 17.**

For more details circle #502 on mailing card.

Lightweight Generating Plant Is Self-Contained and Portable

Full-capacity Direct Current electric power is provided with the new Onan portable 5000 watt generating plant. The completely self-contained unit is lightweight and portable and will provide power to operate lights, universal motors and other equipment requiring direct current power. It is operated by an easy starting two-cylinder gasoline engine which is specifically designed for smooth running, heavy duty, economical electric plant operation. **D. W. Onan & Sons Inc., 2515 University Ave. S. E., Minneapolis 14, Minn.**

For more details circle #503 on mailing card.

(Continued on page 220)

Micromatic Veining in Reenforced Vinyl Flooring

New designs and new sizes are now offered in Vina-Lux flooring. Vina-Lux reenforced vinyl is now available in 1/16, 3/36 and $\frac{1}{8}$ inch in Micromatic Veining. Also in the same thicknesses, the new V-342 Capestrano reenforced vinyl-asbestos has a beige background with light brown and white Micromatic Veining. There are now 21 colors in the Vina-Lux Line.

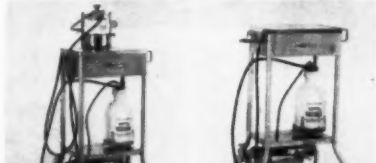
Two new patterns have been added to the line of Azphlex vinylized tile, both colors in 3/32 and $\frac{1}{8}$ inch thicknesses. Azrock asphalt tile in C-59 Walnut is another new addition to the line. **Azrock Products Division, Uvalde Rock Asphalt Co., Box 531, San Antonio, Texas.**

For more details circle #504 on mailing card.

Improved Stand Units for Suction Equipment

The No. 900 Suction and Ether Unit and the No. 901 Suction Unit have been redesigned for convenience, beauty and quiet operation. A new 15 by 11-inch stand, 34 inches high, is now supplied for the No. 900 Suction and Ether Unit. It is graceful yet sturdy in design, has a large accessory drawer, softread conductive rubber tired casters, stainless steel top fittings in chrome-plate and Gomco Lumitone finish. A new micrometer-type regulator indicates the ether flow in the improved unit and the Gomco Aerovent Overflow Protection automatically prevents suction overflow.

Suction Unit No. 901 is equipped with the same new mobile, non-tipping stand. It has suction facilities only with the Gomco Aerovent Overflow Valve. Both units are explosion-proof and have Un-

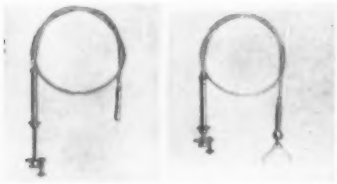


derwriters Laboratory seal and C.S.A. approval for safety, according to the manufacturer. **Gomco Surgical Mfg. Corp., 828 E. Ferry St., Buffalo 11, N. Y.**

For more details circle #505 on mailing card.

WHAT'S NEW

Ayre Stomach Brush for Cancer Detection



A simple and efficient means of early cancer detection is offered in the Ayre Rotating Stomach and Colon Brushes. The brushes are described by the designer, J. Ernest Ayre, M.D., as safe to use, easy to introduce, painless, and requiring minimum patient preparation. The complete unit, approximately 38 inches long, has a metal handle at one end and a wing type brush encased in a metal tip at the other end. A pliable polyethylene tube, through which a stainless steel rotating cable is passed, connects the rotating brush tips with the rotating handle.

After the instrument tip is inserted into the stomach or colon, the brush tips are ejected and rotated to collect a rich concentration of cells. The handle is retracted, drawing the brush into the metal tip for withdrawal of the instrument. The brush bristles are of a type having a special affinity for cellular material and are effective in gathering a high cell concentration for diagnosis. **Clay-Adams, Inc., 141 E. 25th St., New York 10.**

For more details circle #506 on mailing card.

Surgical Instrument-Milk Lubricates Without Oils

The result of years of research and development, Surgical Instrument-Milk is a new product designed to lubricate fine surgical instruments without oil. Instruments are protected from rust, permitting sharps to be autoclaved. The new product is simple to use. Instruments are cleaned in the regular manner, dipped in a bath from the milky white concentrate, drained for a few minutes and are then protected, ready for autoclaving. **Snowden-Pencer, Corp., P. O. Box 186, Los Gatos, Calif.**

For more details circle #507 on mailing card.

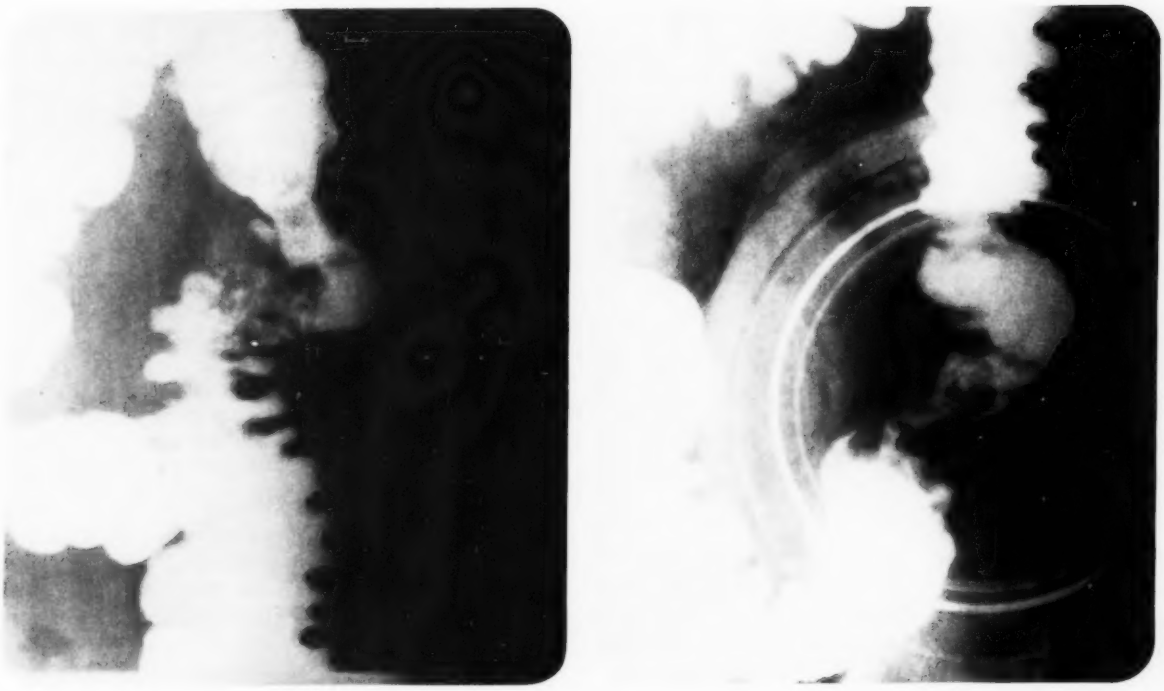
Double Decanter Serves Iced Tea and Coffee

Both iced tea and iced coffee can be served from the same decanter with the DD23. The Cecilware Double Decanter has a capacity of two gallons of iced coffee and three gallons of iced tea. New self-closing Tomlinson faucets facilitate service and are easy to maintain. The stainless steel unit with welded urn seams is 11 by 26 inches in size, requiring minimum counter space. **Cecilware-Commodore Products Corp., 199 Lafayette St., New York 12.**

For more details circle #508 on mailing card.

(Continued on page 223)

72¢ ANSCO X-RAY COSTS



GUIDED THIS $1475 LIFE-SAVING COST

The Ansco medical X-ray film which showed carcinoma of the descending colon cost a mere 72c each. Their value to the hospital was immeasurable. Clear and definitive, these radiographs served as a guide for surgical treatment. Cost of treatment, $1475. Life of patient, priceless.

It's vitally important to consider diagnostic values, rather than price, in choosing Ansco X-ray films. With Ansco, you give your staff maximum diagnostic values, uniform quality. Ansco X-ray films are always:

- tested physically for base strength, flexibility and dimensional stability
- tested photographically for sensitivity—so that bones and soft tissues show with unexcelled clearness
- tested repeatedly for uniformity long after film has left the factory.

BUY ANSCO PROCESSING CHEMICALS

Ansco High-Speed X-ray Films assure constant fidelity to image. 25 sheet and 75 sheet packages.

Liquadol Developer works faster, lasts longer than powder. 1 gal. 5 gal. 20 gal.

Liquadol Replenisher more than doubles the life of Liquadol Developer. Maintains constant developing time. 1 gal. 5 gal. 20 gal.

Liquafix (liquid) provides positive fixing-hardening action. 1 gal. 5 gal.

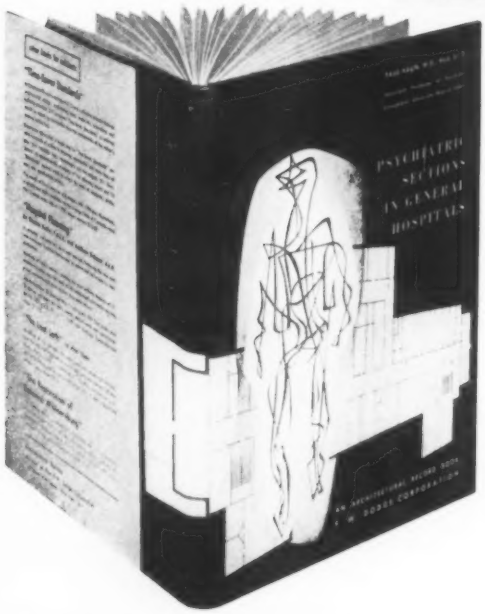
Powdered X-ray Fixer is non-staining. 1 gal. 20 gal. 50 gal.

Ansco BINGHAMTON, NEW YORK.
A Division of General Aniline & Film Corporation

an important guide to the principles of psychiatric construction

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS

By Paul Haun, M. D.



80 pages • 7 x 10" • 16 plans
clothbound with attractive jacket
$4.00

Starting with the thesis that the psychiatric section of the local general hospital is a vital supplement to the state psychiatric hospital, Dr. Haun proceeds to outline the planning considerations for this section, and to relate the treatment and patient-staff routine that will take place within it to the necessary architectural considerations.

TYPICAL HOSPITALIZATION OUTLINED

The reader is given an account of a typical hospitalization in which a patient's movements are traced from his admission to his discharge. The influence of good design is shown at each step of treatment and recovery. Then follows an itemized list of facilities necessary to meet the requirement of an adequate psychiatric unit.

EIGHT FLOOR PLANS RATED

An entire section is devoted to an analysis and rating of eight plans for psychiatric floors in general hospitals. The plans show floors from 12,000 to 17,000 square feet, in general hospitals of 150 to 250 bed size. The desirable and undesirable aspects of the central area, disturbed nursing unit, and quiet nursing unit are summarized.

A final section attacks the problem that a good floor plan for a general hospital is usually *not* a good plan for its psychiatric floor, and vice versa. After discussing the compromises to be made, complete floor plans for a 6-floor, 200 bed hospital, with the psychiatric section on the top floor, are shown.

ANSWERS HUNDREDS OF QUESTIONS LIKE THESE:

How many square feet per patient should be provided in the solarium?

What is the proper location of the nurses' station?

Why is a centrally located nourishment kitchen unadvisable?

What is the maximum practical duration of psychiatric hospitalization in a general hospital?

What security features should be incorporated into the stairwell in psychiatric sections? the bathroom? the windows?

These are typical of the questions answered in *Psychiatric Sections in General Hospitals*—a unique book that every hospital administrator should read.

OUTLINE OF CONTENTS

ORDER NOW ON 10-DAY FREE TRIAL

DODGE BOOKS, F. W. Dodge Corporation, 119 W. 40th St., N.Y. 18, N.Y.

Send me a copy of PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS *for 10 days free examination. At the end of that period I will either remit $4.00 plus a few cents postage, or return the book and owe nothing.*

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☐ My check is enclosed. Same return privilege, DODGE pays postage.

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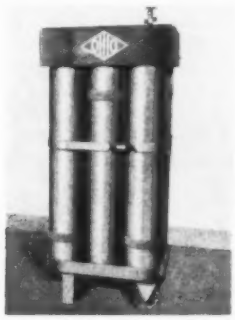
WHAT'S NEW

Bulk Oxygen Stored in Six-Cylinder Cradle

A flexible, versatile supply unit for bulk oxygen is now available in the new Six-Cylinder Cradle. The attractive unit



blends into any location and can be installed either inside or outside the hospital, and set on a slab or platform. It permits rugged, trouble-free and inexpensive installation and provides quality construction and design. The easily-expandable unit offers a continuously reliable source of oxygen supply. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington, Madison 10, Wis.**

For more details circle #509 on mailing card.

Dual-Purpose Car Becomes Ambulance

The new Chrysler Town and Country Wagon is a dual-purpose car which quickly converts to an ambulance when needed. The station wagon-type vehicle has a rear seat which is split into one-third and two-thirds sections. The one-third provides a seat for an attendant.

Named "The Professional," the vehicle has removable plexiglas window inserts

with ambulance insignia, beacon, siren, litters and airplane-type draw curtains for rear side windows. It has extra load-carrying capacity and is equipped with Goodyear Captive Aire tires. The converted Chrysler Town and Country Wagon, in either Windsor or New Yorker series, is available through the National Body Manufacturing Company of Detroit, National Body Corporation of Knightstown, Indiana, and other special automotive body manufacturers. **Chrysler Corp., 12200 E. Jefferson Ave., Detroit 14, Mich.**

For more details circle #510 on mailing card

(Continued on page 224)

Peri-Pack Combination is Pre-Wrapped

The new Pre-Wrapped Modess Peri-Pack is a combination unit offering complete perineal care in a single-package unit. A new fabric of rayon and cotton covering the Modess Pad makes it softer and more comfortable for patient use. It is chafe resistant and will not catch in sutures.

Four large-size Preptic Absorbent Rayon Balls are also included in each packet. They have a high rate of absorbency and are easy and safe to use. The new Pre-Wrap combination offers superior convenience with economy.

Hospital Division, Johnson & Johnson, New Brunswick, N.J.

For more details circle #511 on mailing card.

WHAT'S NEW

Food Service Conveyor of All Stainless Steel

The new Lamson Pin-Type Food Service Conveyor is especially adaptable to

installations where a number of horizontal turns are required. The new conveyor can carry up to twenty trays a minute without upsetting the contents. It has one-piece stainless steel construction which simplifies cleaning and nylon wear strips ensure long, quiet operation without maintenance. Trays can be placed on the conveyor at any point. **Lamson Corporation, Syracuse 1, N.Y.**

For more details circle #512 on mailing card.

Re-Usable Wound Closure Speeds Suturing

Fast and virtually painless wound closure is claimed for the Scott's Steel Stitch. The stainless steel re-usable wound closure is especially applicable where fine-line scars, negligible stitch scars, hurried closures and painless stitch removal are desirable. The trocar-pointed "Steel Stitch" is rolled through the wound with an ordinary needle holder in such a way as to approximate the skin edges. It is left in position and the handle anchored with a narrow strip of adhesive dressing until the wound heals. Upon removal, the handle is grasped with an ordinary hemostat and the hook is rolled out painlessly. Time, anesthesia and materials are saved through repeated use of the new Steel Stitch. **United Surgical Supplies, 154 Midland Ave., Port Chester, N.Y.**

For more details circle #513 on mailing card.

Floor Machine For Small Areas

Designed for areas too small for large, heavy machines, the Lawlor-ette floor machine is an economical all-purpose machine which scrubs, flood rinses, picks up and polishes. Only 17 inches wide, it can be turned easily in small areas. All controls are centralized for one man operation. The Lawlor-ette floor machine moves on non-marking rubber tires and operates from 110 A.C. outlets. D.C. models are also available. **S. C. Lawlor Co., 124 N. Aberdeen St., Chicago 7.**

For more details circle #514 on mailing card.

Visual Control Panels for Record Files

The new Visual Control Panels for record files offer flexibility which permits their adaptation to any individual record requirements. The lightweight panels contain from 25 to 100 clear plastic tubes in 17, 30 and 40-inch widths. The tubes are individually removable and easily shifted from one position to another. Various sizes and colors of signals are available, offering almost limitless signalling and charting possibilities.

Signals snap on or off at any point, slide smoothly back and forth, yet hold position until positively moved. The insertable index feature permits signalling

by position, by color and by legend of index. The system can be applied to practically any kind of control records. **Acme Visible Records, Inc., Crozet, Va.**

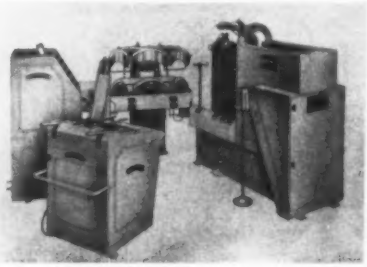
For more details circle #515 on mailing card.

OM NO.	DESCRIPTION	CHARGE	CREDIT	BALANCE	MEMO	DESCRIPTION	CHARGE
212			75.00-	75.00•		CS	
212	ROOM	11.50+9				ROOM	11.50
	DRUG	2.75+2				DRUG	2.75
	XRAY	14.00+1				XRAY	14.00
	EKG	15.50+7		31.25•		EKG	15.50
212	DRESSGS	1.85+4				DRESSGS	1.85
	LAB	4.00+9				LAB	4.00
	PHYTHPY	12.00+6				PHYTHPY	12.00
	ROOM	11.50+9		1.90•		ROOM	11.50
212	DRUG	2.25+2		.35•		DRUG	2.25
212	NUR	6.75+9				NUR	6.75
	DELROOM	15.00+9				DELROOM	15.00
	TRANSFU	18.00+8		40.10•		TRANSFU	18.00
212	ROOM	11.50+9		51.60•		ROOM	11.50
212			25.00-	26.60•		CS	
212	DRESSGS	2.35+4				DRESSGS	2.35
	DRUG	7.50+2				DRUG	7.50
	OXY	10.00+9				OXY	10.00
	TRAY	1.65+3		48.10•		TRAY	1.65
212	ROOM	11.50+9		59.60•		ROOM	11.50

WHAT'S NEW

Glide-O-Matic Features Fast Pressing

The Glide-O-Matic two-girl, three-press finishing unit for pressing shirts and special uniforms has two new features



designed to improve the quality of pressing and increase the speed of operation. A full yoke press on the traveling buck of the Model B.A.S. automatically presses the yoke while the operator is laying out the bosom and body form on another press. Warpage is eliminated as the head is of highly chromed semi-steel construction. The buck automatically glides into a cabinet where front and back are quickly pressed. Clamps release automatically when the buck returns, permitting fast removal of finished work.

An automatic sleeve measuring device is another new feature of the unit. After positioning both sleeves on the forms, the operator moves the measuring handle to set the limits of the pressing area for each sleeve, assuring perfect pressing regardless of sleeve length. The Model STH triple-head collar and cuff press finishes the operation, ready for the folding table. The entire unit occupies only ten feet three inches by eleven feet of floor space. It is compact and eliminates unnecessary steps for operators. Rugged construction, simple design and efficient operation are incorporated into the unit which is available in a choice of seven decorator colors. **The Unipress Co., 2800 Lyndale Ave. S., Minneapolis 8, Minn.**

For more details circle #516 on mailing card.

Varying Surface Designs in Vicrtex Vinyl Fabrics

An illusion of varying surface heights and depths is created in the new Vicrtex designs recently introduced. An exclusive lenticular process is used in embossing the surface of the vinyl fabric to reflect light, while the design of the pattern directs and shadows the reflections.

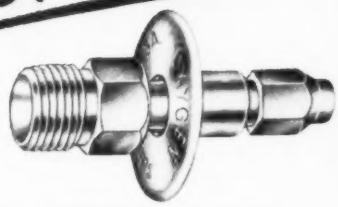
The Continental pattern gives the appearance of quilting. The Translusion design simulates the play of light in blocks of molten glass. The new fabrics are suggested as wall coverings or for upholstery by the designers. They are waterproof, weatherproof, fadeproof, flame, stain and soil resistant and are easily cleaned. **L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1.**

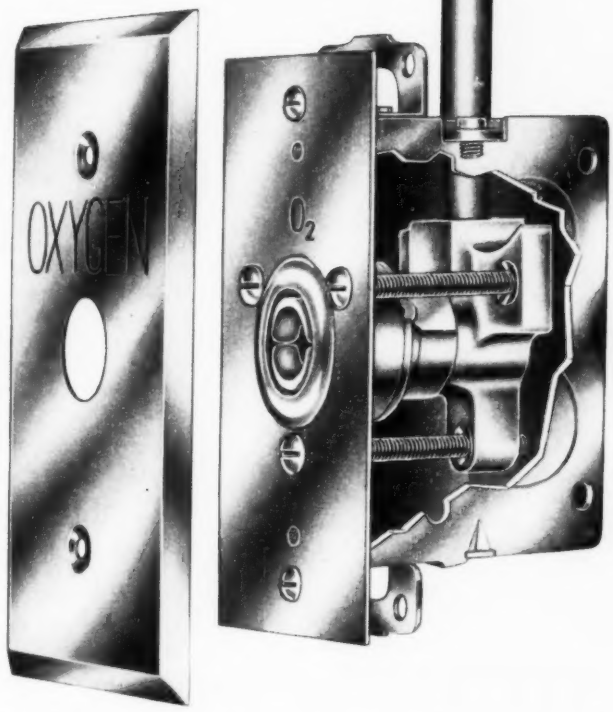
For more details circle #517 on mailing card.

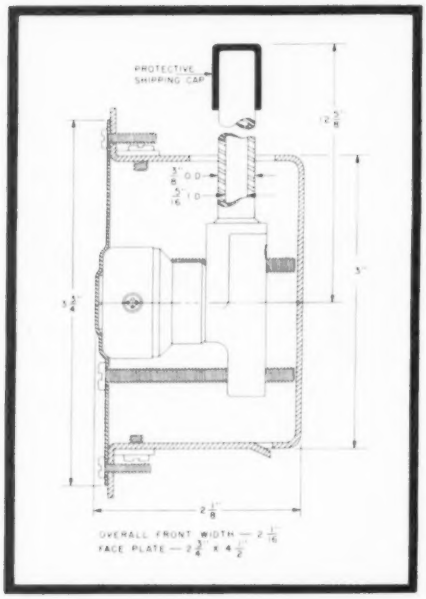
(Continued on page 228)

NOW! Oxygen, Nitrous Oxide, and vacuum outlets like your electric wall outlets—

FLUSH MOUNTED!







Now hospitals can install oxygen, nitrous oxide, and vacuum outlets for piped-distribution systems as easily as electric wall outlets. You can flush-mount the single or multiple wall boxes in any desired combination of services.

Just plug in or disconnect with one motion. Only one hand is needed—fast, foolproof, easy.

To avoid tragic errors, each service is safety-keyed. Plug-in adapters are absolutely non-interchangeable, and even keyed by color to match the gas handled.

Complete, ready-for-installation face plate, wall box fully assembled in one package. Units are capped so dirt—and dust-free installations—can be made. Tamper-proof plugs are available for especially vulnerable locations.

NON-SWIVEL OXYGEN ADAPTER to hold flow meters or humidifier bottles in upright position.

NON-SWIVEL OXYGEN ADAPTER with swivel nut connection.

NITROUS OXIDE ADAPTER safety-keyed to fit only nitrous oxide outlet.

NON-SWIVEL VACUUM ADAPTER safety-keyed to fit only vacuum outlet.

Mail the coupon for full information on Schrader flush-mounted wall outlets, and Schrader exposed wall outlets.

A. SCHRADER'S SON, Div. of Scovill Mfg. Co., Inc.
470 Vanderbilt Ave., Brooklyn 38, N. Y.

Please send me full information about Schrader Hospital Gas Outlets that are designed for flush mounting.

Name_____

Position_____

Hospital_____

Address_____

Schrader®
a division of **SCOVILL**

FIRST NAME IN THE SAFEST
MEDICAL GAS CONTROL OUTLETS

WHAT'S NEW

Automatic Tea Maker Makes High Quality Brew

Cooperation between the National Restaurant Association, the Tea Council

of the U.S.A., Inc., and the Food Machinery and Chemical Corporation resulted in the production of an automatic tea maker designed to serve uniformly better tea with less trouble in institutions. The machine is fully automatic in operation and makes either hot or iced tea immediately available at all times.

The FMC TeaMaker is a stainless steel unit 16 inches wide, 21 inches deep and 30⅛ inches high, without legs. Four inch legs are available if desired. The self-contained, thermostatically controlled electric water heater maintains a constant supply of 200 degree F. water, which heat is described as ideal for making tea. The TeaMaker is easy to operate, reduces labor in tea preparation, speeds serving and produces uniformly superior tasting tea, according to the report. With the eight-ounce infuser, 500 cups of hot tea or 400 glasses of iced tea can be served in an hour. **Food Machinery & Chemical Corp., Kitchen Equipment Dept., Hoopeston, Ill.**

For more details circle #518 on mailing card.

Two Desserts Added to Food Line

A new gelatine dessert and a new pudding dessert have been added to the Seidel line of institutional foods. Crab-Apple Gelatine Dessert adds taste variety and eye appeal with its bluish-pink color. Chocolate Mint pudding combines the flavor of milk chocolate with a touch of refreshing mint. **Ad. Seidel & Son Inc., 1245 W. Dickens Ave., Chicago 14.**

For more details circle #519 on mailing card.

Complete Cobalt 60 Therapy in Compact Low-Cost Unit

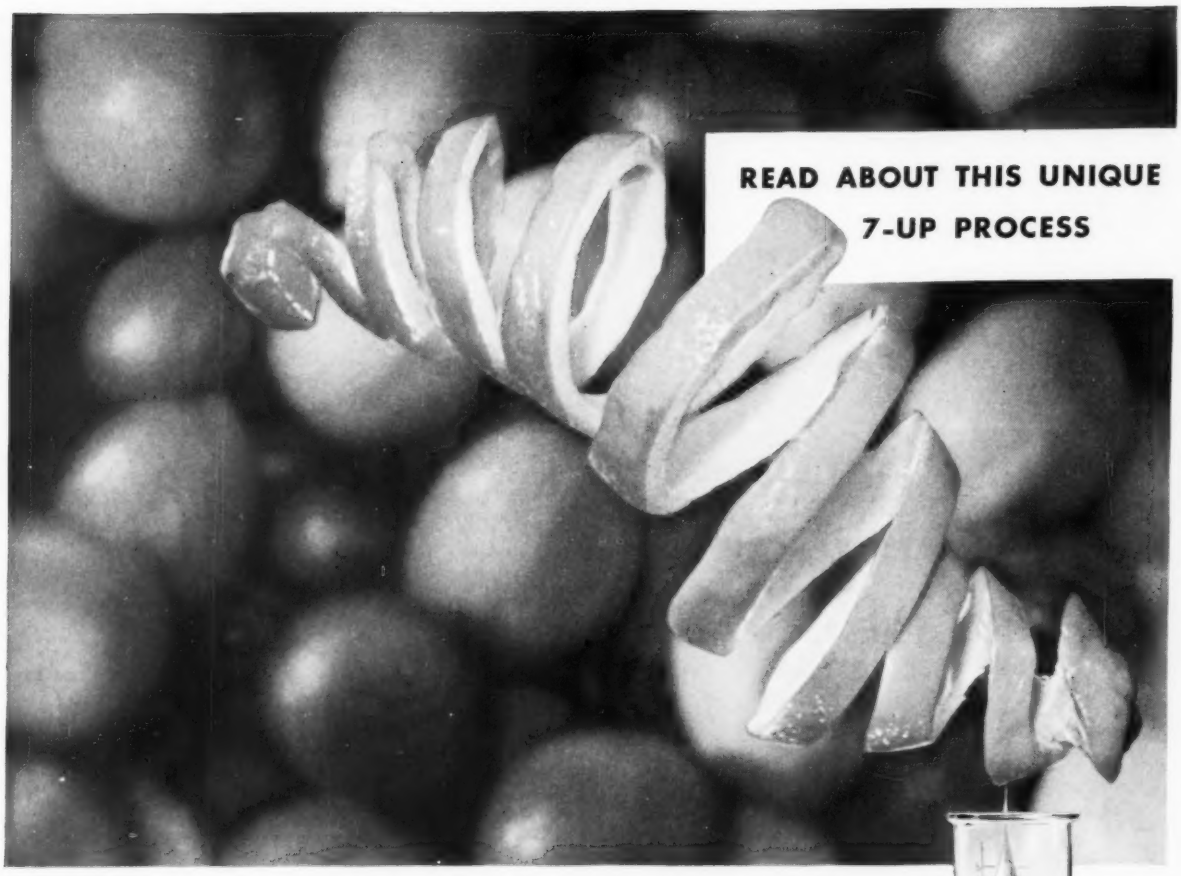
The "Commando" is a compact, low-cost unit offering complete facilities for full range radiation therapy procedures. Cobalt 60 teletherapy with the "Commando" unit is designed to comply with the latest recommendations of the National Committee on Radiation Protection, according to the manufacturer. It is constructed for easy installation in almost every location.

The new unit utilizes a one cm. diameter source up to 150 curies of high specific activity Cobalt 60. Treatment distances down to 22 cm. are said to be possible with the new unit. The 31-inch vertical travel of the unit is powered by a dual speed motor drive. One hand

operation is offered with counter balance for finger-tip control of angulation in the vertical plane. **The Dick X-Ray Co., 4000 Olive St., St. Louis 8, Mo.**

For more details circle #520 on mailing card.

(Continued on page 230)



Only the quintessence... is good enough for 7-UP

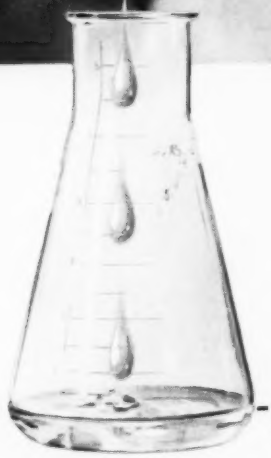
We had to go some to outwit Nature and perfect 7-Up.

Nature hid 7-Up's secret well—inside the *peel* of fresh lemons and limes. There, in minute quantities, a fragrant oil resides which penetrates the "meat" of citrus fruits to create their clean, tangy flavor.

Extracting this natural fruit essence takes special equipment, time, care and money. From this, 7-Up refines and selects only a tiny fraction—the very best—for use in the extract from which 7-Up itself is made.

To produce 1 ounce of concentrated 7-Up flavor literally takes thousands of fresh lemons and limes. That's why 7-Up is Nature's own gift . . . a pure, wholesome, natural flavor.

For a fresh, clean taste . . . 7-Up.



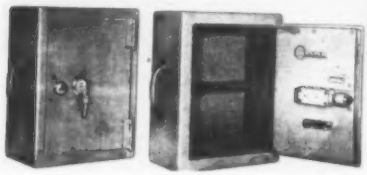
TO EXTRACT ONLY
1 OUNCE
OF 7-UP FLAVOR ESSENCE
WE SQUEEZE THE PEEL OF
THOUSANDS
OF FRESH LEMONS
AND LIMES

7up

Nothing does it like Seven-Up!

WHAT'S NEW

Narcotics Safe Has Re-Locking Device



A re-locking device makes the Protectol Safe a tamperproof unit for safeguarding narcotics. It is described as having Underwriters Laboratories approval and as complying with new Federal and State regulations for the safe handling of narcotics. The Protectol Safe weighs 57 pounds, can be carried, wall mounted or bolted down. **Harold Supply Corp., 100 Fifth Ave., New York 11.**

For more details circle #521 on mailing card.

Automatic Cycling for Breathing Unit

The Bennett unit for intermittent positive pressure breathing therapy can now be converted to an automatic cycling resuscitator with the new Bennett Automatic Cycling Attachment. The new attachment creates a combination breathing therapy unit and emergency resuscitator when attached to the face of the Bennett TV-2P or PV-3P models. Use of the automatic cycling feature is optional without removal of the attachment and

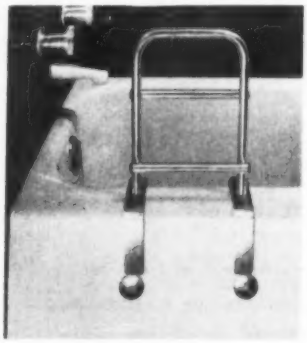
the attachment itself can be disengaged instantly without removal when cycling is not required.

The Bennett units with Automatic Cycling Attachment can now provide automatic respiration or reduce patient effort in post-operative recovery, respiratory paralysis and other emergency situations in the recovery room, admitting room or other areas of the hospital. **V. Ray Bennett & Associates, Inc., 2230 S. Barrington Ave., Los Angeles 64, Calif.**

For more details circle #522 on mailing card.

Bathtub Grip Helps Prevent Falls

Hand-hold security in the bathtub is offered with the new Self Ease Safety Bathtub Grip. The three levels provide support for child or adult, either standing or prone. The Self Ease Grip attaches



to, or removes from a bathtub rim in a matter of seconds by means of adjustable, steel screw clamps, bonded with corrugated rubber to prevent marring of tub porcelain, or slippage. It is constructed of 16-gauge steel tubing, with heavy-duty chrome plate finish. Two models are available for bathtubs of varying rim widths. **Self Ease Units, Inc., 1026 Park Ave., New York 28.**

For more details circle #523 on mailing card.

(Continued on page 232)

Light Source for Photomicrography

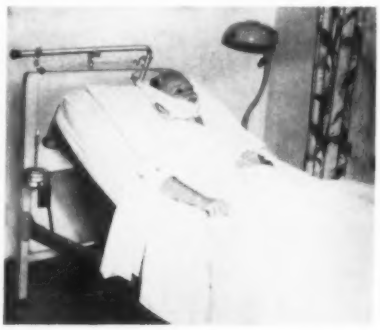
A steady high intensity source of light for normal viewing and focusing in photomicrography is available in the new Type 505 "Pulsarc." It is capable of being pulsed at a much higher input at the time the photographic exposure is made. The increased power in the pulse results in an increase in the intensity of the xenon arc lamp without an appreciable increase in the size of the source. The time of the light pulse in the unit can be varied. The pulse can be synchronized by the usual camera shutter contacts.

Color temperature of the "Pulsarc" approximates daylight, permitting use of daylight color films. **Hospital Equipment Div. Overseas Service Corp., Dupont Circle Bldg., Washington 6, D.C.**

For more details circle #524 on mailing card.

Entire Frame Elevates for Cervical Traction

The new DePuy Cervical-Pelvic Traction Frame permits elevating the entire frame with backrest without disturbing cervical traction of the patient. The



frame is quickly attached to any hospital bed, the supporting base clamping to the bed spring frame. It can be set up without the need for moving the bed out from the wall. For pelvic traction the unit is set up at the foot of the bed with the pulley-bar inverted for greater height. The No. 700 Frame is sturdily constructed and folds flat for storage. **DePuy Mfg. Co., Inc., Warsaw, Ind.**

For more details circle #525 on mailing card.

Commercial Incinerators Available in Four Sizes

Designed to meet or exceed the requirements of municipal codes, the new Series "S" Incinerators for commercial use are offered in four sizes: 7, 10, 15 and 20 bushel capacities. They feature top

feed with low loading height, a special Dehydrating Hearth to dry out refuse efficiently, three Secondary Expansion Chambers with extra long fire-travel and down-draft design to eliminate smoke and odor, and economical price. The Model "S" can be installed indoors or out and is available for burning dry refuse without fuel. Automatic controls, over-fire burners and other special equipment are optional. The new incinerators can be equipped to burn natural or bottle gas, oil or electricity. **Winnen Incinerator Co., 932 Broadway, Bedford 32, Ohio.**

For more details circle #526 on mailing card.

(Continued on page 234)

Aircraft makers use

NIBROC® TOWELS

more than any other paper towel

HOSPITAL ADMINISTRATORS, too, prefer the *new* Nibroc towels. They're stronger, softer, friendly to the face, and absorb water like lightning. In white they're the whitest you've seen—product of an exclusive new "white magic" bleaching process. And new manufacturing methods have vastly improved Nibroc towels in the natural shade, too.

Used more by industry and institutions than any other, Nibroc is the first and today more than ever the finest wet strength towel. To save, buy Sofwite® and Softan® tissues. Your dealer will furnish samples, tell how Nibroc reduces towel costs. He's listed under Paper Towels in Yellow Pages. Or write Dept. NP-6, Brown Company, 150 Causeway St., Boston 14, Mass.

Other NIBROC Quality Products: INDUSTRIAL WIPERS • WINDSHIELD WIPERS • KOWTOWLS • WALL, FLOOR, and RECESSED CABINETS

WHAT'S NEW

Complete Place Setting Now Available in Paper

Attractive paper dishes are now offered by Lily-Tulip in complete place settings.

A sample kit is available for use as a guide in ordering the complete service or special items. Included in the new service are an eight-ounce container for soups, stews or spaghetti; cold cups from four to ten ounces in capacity; ¾ and one-ounce cups for creams and sauces; four and six-ounce pleated dishes for salads and desserts, and Lily portion cups from one-half to five and one-half ounces for relishes, puddings and similar uses.

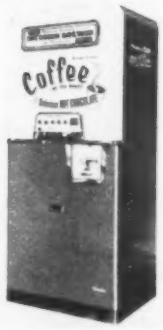
Plastic-coated and uncoated plates in a variety of sizes are included in the kit which also contains six and eight-ounce hot cups with handles and seven-ounce hot cups without handles, as well as the new Lily China-Cote hot drink cup in the eight-ounce size. Lids are included for several containers and cups and a paper place mat complete the attractive setting. **Lily-Tulip Cup Corp., 122 E. 42nd St., New York 17.**

For more details circle #527 on mailing card.

Vending Machine Uses Regular Coffee

The new Vendo Coffee Vending Machine uses vacuum-packed cans of coffee for on the spot brewing. Called infusion brewing, a can of coffee is automatically punctured at both ends when the machine is activated. Jets of hot water are forced through under pressure and the coffee acts as a filter with the grounds remaining in the can for easy disposal.

The vendor holds 54 cans, each of which produces approximately 16 cups



of coffee. The customer has five choices: black, with cream, with sugar, with cream and sugar, and with double sugar and cream. Hot chocolate is also available in the machine. **The Vendo Co., 7400 E. 12th St., Kansas City 26, Mo.**

For more details circle #528 on mailing card.

Remote System for Radiation Monitoring

Hospital personnel working in areas where radio isotopes are being used can be protected through use of the new remote multi-channel radiation monitor system recently introduced. The system is effective for area and background monitoring for personnel protection, exposure and health monitoring, and film exposure determination. Model UAC450 is a compact five-channel master console type remote monitor located at a central control station and can be used to monitor radiation up to several thousand feet away in each of five different locations. Each channel is independent of the others and is connected to an automatic alarm. **Universal Atomics Corp., 143 E. 49th St., New York 17.**

For more details circle #529 on mailing card.

Louvered Fluorescent Unit for Low Ceilinged Rooms

The all-steel Smithcraft "Executive" is a shallow louvered fluorescent unit for use in low-ceilinged rooms. It is modern in design and its tapered sides are self-

illuminated, reducing contrast. The egg-crate louvers provide a shielding of 30 degrees crosswide and 45 degrees lengthwise. The new "Executive" is available with open top for uplighting or with top reflectors for 100 per cent downlighting. It may be mounted individually or in continuous rows, surface or pendant. **Smithcraft Lighting, Chelsea 50, Mass.**

For more details circle #530 on mailing card.

Emergency Unit for Oxygen Therapy

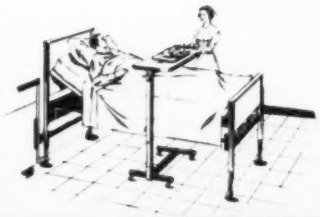
Instant oxygen therapy is provided with the new portable O.E.M. Emergen-Ox unit. The nine-pound kit is approximately the size of a brief case and contains two I.C.C. approved cylinders of oxygen, a U.S. approved regulator, a permanent or disposable non-rebreathing mask, a special filler adapter and a strong carrying case.

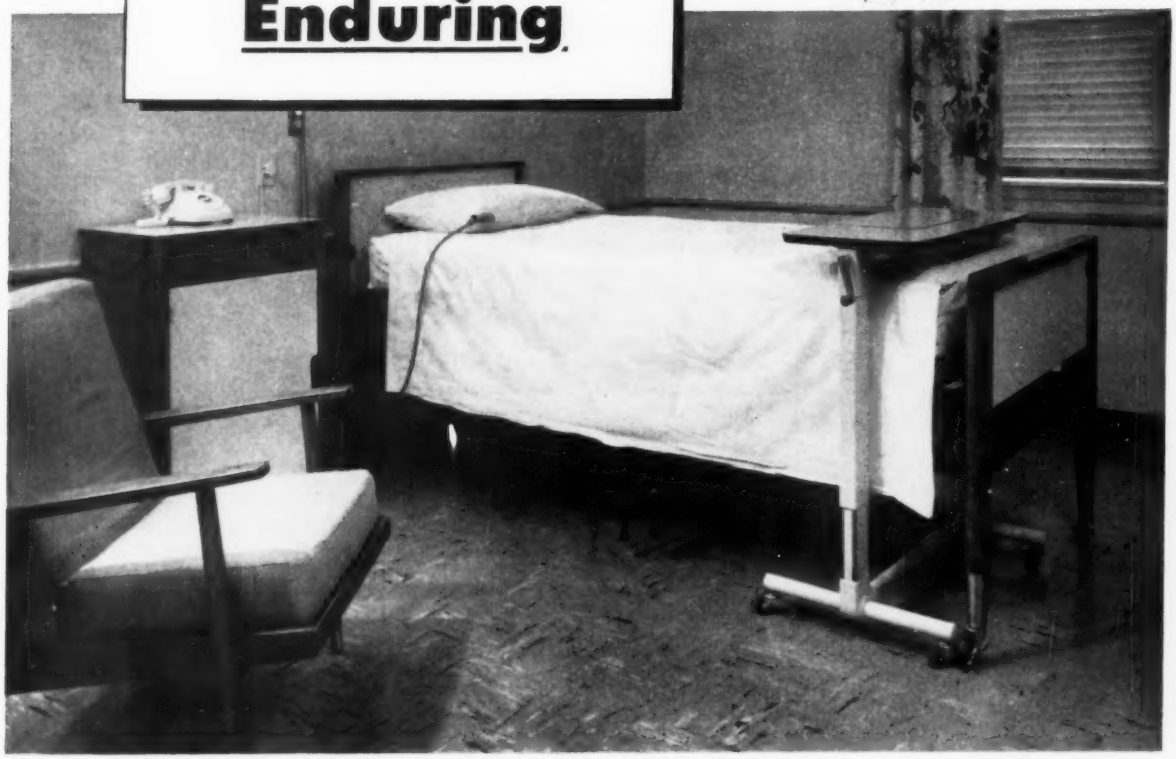
The unit supplies up to 25 minutes of oxygen for emergency administration, making it effective for use in the emergency department, ambulance and other areas where quick administration of oxygen is required. The liter flow rate on the portable unit is adjustable and the pistol-type regulators have a safety relief valve. **O.E.M. Corporation, 1330 Dolman St., St. Louis 4, Mo.**

For more details circle #531 on mailing card.

(Continued on page 236)

Clean, Quiet, Safe and Enduring





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Azrock Asphalt Tile is built for extra years of top performance under modern hospital conditions. Its tight, smooth surface is hard to stain, easy to clean . . . highly resistant to scuff, indentation or impact . . . yet quiet and slip-safe underfoot. It's economical, too — from *every* standpoint.

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WHAT'S NEW

Wheel Chair Table Features Numerous Adjustments

Almost unlimited adjustments can be made in the newly designed Wheel Chair

Table distributed by Rehabilitation Products Division. The table serves as a work or recreation desk, as a support for patients requiring almost complete arm support, when raised to its high position, and it can be easily adjusted to any position within a 9¼-inch raised limit to a 35-degree tilt.

The table is designed to fit any wheel chair by unique rubber covered spring clamps. All elevation and tilt adjustment knobs are at the side, giving the patient freedom of movement without interference from permanent attachments. The table top is form cut to fit around the patient and is large enough to accommodate patients in respirator chest shells. **Rehabilitation Products, Division of American Hospital Supply Corp., Evanston, Ill.**

For more details circle #532 on mailing card.

Fresh Lemonade Available in Cartons

After careful research in a test market, fresh Sunkist orange juice and lemonade are now being made available nationally through local dairies. The fresh frozen juices of oranges and lemons are delivered to carefully selected dairies with the facilities for making up the fresh orange juice drink and fresh lemonade under sanitary conditions. The resulting flavorful and nutritious beverages are offered in half pint paper containers similar to those used for milk. Patients and hospital personnel thus have the fresh fruit drinks readily available through the dietetic service, cafeterias and lunchrooms or through vending machines.

Dairies licensed to use the Sunkist name and product are carefully selected and part of the licensing agreement includes proper mixing, sanitation, freshness and care in handling. **Sunkist Growers, Products Dept., 720 Sunkist St., Ontario, Calif.**

For more details circle #533 on mailing card.

Kart-Kover Protects Book Truck

Mobile book and gift carts can now be protected from dust and dampness when not in use with the new Samaritan Kart-Kovers. They are made of clear tough plastic material, reenforced at points of wear, which is waterproof and grease-proof and not affected by extremes in temperatures. All seams are stitched with heavy duty thread and the covers are washable for ease in maintenance. The

clarity of material permits viewing of cart contents when covered. It is available in two sizes. **Samaritan Cart Co., Inc., 333 Seventh Ave., York, Pa.**

For more details circle #534 on mailing card.

(Continued on page 238)

INSIGHT

. . . when it is most needed

Insight, at the crucial moment of decision, is often vital to a correct diagnosis. Not only is sound judgement called for, but also the finest instruments at a doctor's command . . . sharp radiographs, for example. That is why radiologists the world over rely on Ilford X-ray films for their reproducibility; for *high speed* to reduce risk of involuntary movement, and for *gradation* to produce the widest possible range of opacities. Ilford X-ray materials, crafted to the highest technical standards, are now available in the U.S.A. Contact your regular supplier, or write to the address below.

Ilford Red Seal X-ray Film • Ilfex (non-screen film) • Ilford Intensifying Screens

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Made in England by ILFORD LIMITED, your source in U.S.A. is ILFORD INC., 37 West 65th Street, New York 23, New York. Your source in Canada is W. E. Booth Co. Limited, 12 Mercer Street, Toronto 2B, distributors for Ilford Limited.

WHAT'S NEW

Thermistor Element Monitors Temperatures

The extreme sensitivity of the thermistor sensing element in the new temperature control unit recently introduced makes it possible to monitor body temperatures in critically ill patients. Variations in temperature as small as .075 degree F. are registered with the new instrument which combines a thermistor in a bridge circuit with a contact meter-relay in a pre-assembled control package. The thermistor sensing element can be located as far as 200 feet from the controller without affecting indicating or controlling accuracy, making it possible to monitor temperatures from the nurses' station or other area outside the patient's room. Models are available in a number of temperature ranges. **Assembly Products, Inc., Chagrin Falls, Ohio.**

For more details circle #535 on mailing card.

Ditto Masterset Has Smudge Protection

A new four-part Masterset for Direct Process (liquid or fluid) reproduction is designed for smudge-free use. An attached protection sheet prevents contact with either the Direct Process carbon

sheet or the finished master, permitting the master to be handled and filed without staining hands, clothes or papers.

The new Masterset consists of the master sheet, tissue separator, Direct Process carbon sheet and the protection sheet. In preparing the master, the tissue separator is removed to permit the master sheet to pick up the dye impression from the carbon sheet which is discarded on completion. The protection sheet acts as a backing to provide a clear, sharp image transfer and protects the dye when the master is filed. **Ditto, Incorporated, 6804 N. McCormick, Chicago 45.**

For more details circle #536 on mailing card.

Mobile Book Truck Has Two-Tiered Cabinet

A two-tiered storage cabinet for general use becomes a mobile book truck when books are to be distributed or collected. An adaptation of the attractive, modern

Brunswick storage cabinets, the unit has easy rolling wheels and extended sides to hold a maximum number of books. The colorful cabinet truck can be assembled from the Brunswick units in scores of door, shelf-divider and mounting combinations to meet the need. Shelf dimensions of the book truck meet the requirements of the wide variety of books used in hospitals. The interchangeable dividers permit assembling the books in categories. **The Brunswick-Balke-Collender Co., 623 S. Wabash Ave., Chicago 5.**

For more details circle #537 on mailing card.

(Continued on page 240)

YOU ASKED FOR IT...

CONVENIENT DISPENSING!

FLEX-STRAWS NOW PACKED
in a convenient DISPENSER BOX

MINIMUM HANDLING...MAXIMUM PROTECTION

FLEX-STRAWS are distributed quickly and efficiently from the new dispenser box. Straws are removed at corrugated section so that it is never necessary to touch either the end which is immersed or the end which touches the mouth; assuring maximum protection and sanitation. One or several FLEX-STRAWS can be dispensed with minimum time and effort. The dispenser tab may be closed between uses. ORDER FROM YOUR DISTRIBUTOR NOW.

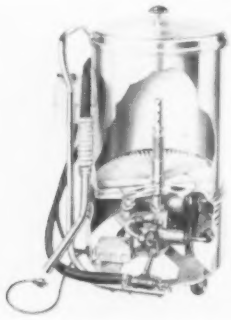
FLEX-STRAW COMPANY 2040 BROADWAY • SANTA MONICA, CALIF.

Canadian Distributors: Ingram & Bell, Ltd. • Toronto

WHAT'S NEW

Filtering Machine Saves Cooking Fat

The Fry-Saver is a new fat filtering machine which operates without any



filtering aids. Cooking fat filters through a microscopically fine Porosite filter cartridge which removes all sludge and other impurities. The cartridge is replaceable when required and its special handle makes removing a clean and easy task.

The practically automatic method of fat filtering operates like a vacuum cleaner. The unfiltered cooking fat is quickly drained out of the fryer through the Fry-Saver intake hose which simplifies the procedure. If residue remains in the fat chamber, a filtered hot cooking fat flush is pumped back into the fryer, again drawn out and all the filtered fat pumped back into the clean fat chamber. The Fry-Saver is a self-contained electrically operated, portable unit, designed to be used by unskilled help. It is constructed for use with any deep-fat fryer. **S. Blickman, Inc., Weehawken, N.J.**

For more details circle #538 on mailing card.

Electrical Outlets in Modern Design

A contemporary line of electrical outlets, stainless steel, plastic and brass wall plates are now available for installation in modern buildings. Produced in specification grade materials, the new Sierra Plex Receptacles include three-wire grounding-type and two-wire convenience receptacles for lamps, appliances and other equipment. The simplified, modern lines and quality production make these accessories desirable for use in new buildings and institutional construction.

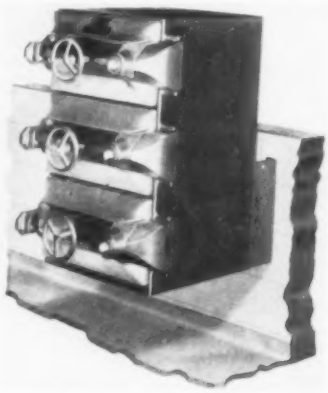
They are available in either ivory or brown finish and the manufacturer states they meet specifications and requirements of the National Electric Code, Underwriters Laboratories and applicable laws and codes of Federal, State and Municipal departments. **Sierra Electric Corp., P.O. Box 85, 15100 S. Figueroa St., Glendale, Calif.**

For more details circle #539 on mailing card.

(Continued on page 242)

Steam Cooker Is Wall-Mounted

Easy floor cleaning is assured with the new wall-mounted Steam-Chef and Streamliner steam cookers. Two wall-mounted styles have been added to the line. A special steel chair carrier is imbedded in the floor as the steamer support and the finished floor is applied over the carrier base. The heavy uprights which carry the entire weight of the steamer are concealed in the rear wall with only fastening bolts projecting



through the wall surface. Floors are thus left unobstructed. **Cleveland Range Co., 3333 Lakeside Ave., Cleveland 14, Ohio.**

For more details circle #540 on mailing card.

This is the woman that ruined your drive to raise money for the new hospital building program. You saved her life — but she may hate your hospital forever! This article tells you what can be done to overcome these situations at your hospital.

Your hospital saved her life but she may hate you forever

What happens when you take a sick woman and make her like new again — only to be your hospital's enemy for life? What caused her irritation, her distrust and desire to fight your cause at every turn?

Hospital administrators have pondered this vital public relations problem for years. Now, the RYALL Corporation, a firm that has made a specialty of hospital public relations, has the answer to the problem of curing ill will and dissatisfaction, not just on the patient level, but also in nursing and medical staff areas, employee relations and the general public.

When you bring in RYALL consultants, a study is first made to find out what the community and its leadership think of your hospital.

Then, the RYALL public relations director begins setting up a variety of inexpensive programs that are tested and proven techniques for generating good will among patients, medical staff, civic leaders, and the community in general.

The net result is that within six months to a year, the attitude climate may be changed from anti-hospital — to very favorable. With this change in public relations, even a fund-raising program for your hospital could begin with every chance of success.

Why don't *you* fill in the coupon below for more facts about RYALL hospital public relations programs. No cost or obligation. Do it now!

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Dear Sirs: We are interested in your public relations service. Would you please send us further information at no obligation.

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WHAT'S NEW

Dictation Machine Is Portable

The new Peirce Portable Dictation Machine may be used wherever it is possible to dictate. Known as the Peirce Secretary, the machine operates on two self-contained batteries. Weighing only four and one-half pounds, the box-size unit may be used with or without an electrical outlet.

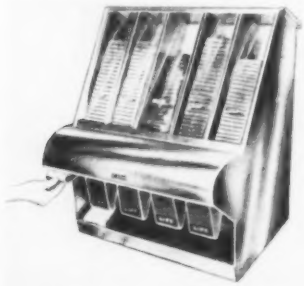
The Peirce Secretary is a complete dictation unit which incorporates instant playback and automatic-erase for error-less dictation. A magnetic dictation belt holds 15 minutes of dictation which may be transcribed on standard office units.

The belt may be used thousands of times. A "talk" and "listen" microphone control starts the motor and an indicator light tells when the machine is running and when the batteries need replacement. **Peirce Dictation Systems, 5900 Northwest Highway, Chicago 31.**

For more details circle #541 on mailing card.

Sanitary Server for Sliced Bread

A new unit for serving sliced bread, buttered or unbuttered, is offered in the redesigned Serv-a-Slice bread dispenser. The attractive stainless steel and safety glass dispenser holds five Pullman loaves of bread, one wide compartment being supplied for rye bread. Bread is dispensed a slice at a time by merely raising the lever under the type of bread wanted.



Safety glass panels on the front make selection easy.

The back of each compartment lowers for easy filling. Cleaning is simplified through the crumb tray, removable from the rear. With the dispenser sliced bread does not dry out and is kept in a sanitary condition. Even buttered bread can be handled by the dispenser. **Serv-A-Slice Industries, 3207 S. Shields, Chicago 16.**

For more details circle #542 on mailing card.

Disposable Container for Absorbent Sodasorb

A new canister-size paper container, which can be discarded after use, is now used to package Sodasorb, the carbon dioxide-absorbent for anesthetic and basal metabolism equipment. The Canister Pak is lined with polyethylene and aluminum foil, heat sealed to maintain the high absorption qualities of Sodasorb. Each container holds just enough Sodasorb to fill a standard size 1640 cc. canister. For other sizes the Pak can be resealed to protect the unused Sodasorb.

The durable new container is convenient to use, easily disposable and safe for shipment and handling. It is quickly opened. The newly-designed twelve Pak carton is readily opened by means of a tear strip, and becomes a convenient carrying tray and compact storage unit. **Dewey and Almy Chemical Co., 62 Whittemore Ave., Cambridge 40, Mass.**

For more details circle #543 on mailing card.

(Continued on page 244)

WHAT'S NEW

Recessed Soap Dispenser Reduces Maintenance Time

A new completely recessed soap dispenser with satin stainless steel finish

gives a modern appearance to all restrooms. The unit employs many construction features which improve its efficiency and reduce maintenance costs.

The 21-ounce dispenser mounted on the back of the locking door swings out for easy servicing. The open mouth design permits quick filling with little spillage. The dispenser has one moving part, the plunger which releases a measured quantity of soap on the up-stroke and will not bleed. A hide-away pan collects user spillage and is easily removed for cleaning only when the door is open to protect against theft. The locking door also prevents vandalism and clogging of dispenser action. **20 Mule Team Products, U.S. Borax & Chemical Corp., 630 Shatto Place, Los Angeles 5, Calif.**

For more details circle #544 on mailing card.

Plastic Surfacing Is Stain Resistant

A new Armstrong material for wall and countertop has been introduced. Called Plastic Surfacing, the material is an all-vinyl composition with an Armstrong Hydrocord backing.

Plastic Surfacing resists stains from soaps, detergents, acids and alkalis and will not buckle under heat or crack from bending or stretching. It is completely moisture resistant on both sides. The material is easy to install and is available in rolls 30 and 42 inches wide. It has a softly textured design available in eight colors. **Armstrong Cork Company, Lancaster, Pa.**

For more details circle #545 on mailing card.

Liquid Floor Finish Has High Luster

Floors are given an attractive long-lasting luster, without buffing, with the new Nu-Hygloss liquid floor finish. For average wear a two-coat application of Nu-Hygloss, after stripping floors, is said to give satisfactory protection and luster that will last for months. An additional coat may be applied for longer protection. Nu-Hygloss is said to contain no solvents or harmful chemicals, is completely slip resistant and resists scuffing. **The Penetone Company, Box 65MH. Tenafly, N.J.**

For more details circle #546 on mailing card.

Lounge Seating Allows Flexible Arrangements

The Perimeter Lounge Seating line was designed to permit a flexible arrangement of attractive and functional seating for hospital lobbies, offices, reception rooms and other areas. The Perimeter line is built around units which can be positioned as single, two or three seaters, with or without arms. Attachable tables are optional, along with corner radius units.

The seating units, constructed of molded foam loose cushion seats with backs of rubberized hair, may be upholstered with leather or fabric in a choice of many colors and patterns. Walnut picture-frame arms may be partitioned with brass, copper, cane or chrome partitions to complete a decorating scheme. **B. L. Marble Company, Bedford, Ohio.**

For more details circle #547 on mailing card.

WHAT'S NEW

Wall-Hanging Fountain in Vitreous China

The Rockbrook is a new vitreous china wall-hanging drinking fountain

introduced by Kohler. The streamlined design features a wide apron, making the fountain easy to clean and modern in appearance. It has an eight-inch back for wall protection and measures 12 by 12 by 16 inches in size. The non-squirting, self-closing valve is adjustable for continuous flow and is equipped with automatic volume regulator. **Kohler Co., Kohler, Wis.**

For more details circle #548 on mailing card.

Fan Ventilators for Quiet Operation

High efficiency and quiet operation at slow speeds are claimed for the two new Centriflow Fan Ventilators recently introduced. Designed for institutional use, where low noise levels are desirable, the ventilators are available in a V-belt drive for large capacities and in a low profile model of spun aluminum for installations requiring lower capacities. Ratings are guaranteed and both units have non-overloading, backward curved blade fan wheels with motors in separate, air-cooled compartments insulated for quietness by resilient rubber vibration pads. The ventilators are especially adapted for use in schools, hospitals, dormitories and other institutions. **The Burt Mfg. Co., 11 E. South St., Akron 11, Ohio.**

For more details circle #549 on mailing card.

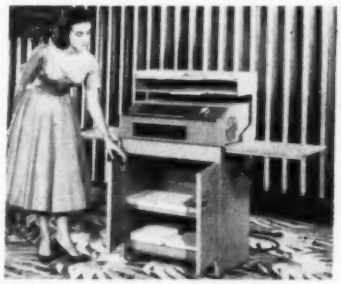
Multi-Link Matting in Many Color Combinations

The new Goodrich Multi-Link Matting is constructed of individual Koroseal links which are available in many colors. The matting is custom-made allowing the institution to select a color combination to coincide with its architecture. The links, available in gray, brown, blue, yellow, black, green, white, red and orange are strung on parallel non-rusting spring steel rods. Mats are finished on all four sides with Koroseal nosing which may be either square or tapered. Koroseal links are said to resist aging, abrasion, acids, caustics and oil. **B. F. Goodrich Industrial Products Co., Akron, Ohio.**

For more details circle #550 on mailing card.

Table-Top Copying Machine Has Cabinet Floor Stand

A new cabinet floor-stand which provides storage space for copy paper and other office supplies is available for use with both of the new Thermo-Fax table model copying machines, the "Fourteen" and the "Premier." The Thermo-Fax "Fourteen," illustrated, copies material up to 14 inches in width. Copy paper and original are fed into the machine and re-



turn automatically in four to seven seconds with an exact replica on the copy paper. **Minnesota Mining & Mfg. Co., 900 Fauquier St., St. Paul 6, Minn.**

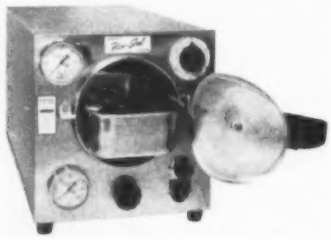
For more details circle #551 on mailing card.

(Continued on page 246)

WHAT'S NEW

Flex-Seal Pressure Cooker Now Offered in Counter Model

The new Counter Model No. 50 of the Flex-Seal Speed Cooker comes complete with steam generator, yet occupies only 12 by 22 inches of counter space and



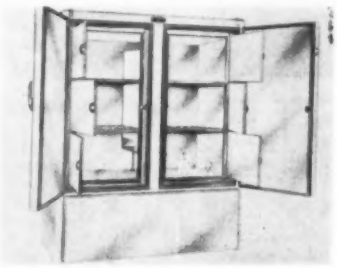
is only 12 inches high. The development of a small, instantaneous, automatic Electric Steam Generator has made the small size of the new pressure cooker possible. Safety devices are built into the unit to prevent burn-out and other damage. If the water supply is not turned on at the same time as the electric power, the unit will not operate, preventing burn-out. When the Steam Generator is turned off after the day's use, the entire unit is self-flushing, leaving the interior dry to prevent build-up of lime or other deposits.

The cooker operates automatically after the timer is set and the door is closed. There is no pre-heating, no water to add and even frozen foods are perfectly cooked without defrosting when the indicated time-table is followed. The new model cooks all types of foods quickly, easily and safely. The stainless steel construction simplifies cleaning and assures a constantly attractive appearance. **Vischer Products Co., 2815 W. Roscoe St., Chicago 18.**

For more details circle #552 on mailing card.

Upright Freezers Have Automatic Defrost

The new Fostermatic Automatic Defrost system is a feature of the 1957 line of Foster Upright Freezers, including four basic remote models and seven basic



self-contained models. Model LR40-U, illustrated, is designed for regular food storage. It has a 40-cubic foot freezing area and is of all aluminum construction. **Foster Refrigerator Corp., Mill & N. Second Sts., Hudson, N.Y.**

For more details circle #553 on mailing card.

Oil Enema in Disposable Package

Pharmaseal Oil Retention Enema is now available in a prepackaged disposable container. The oil retention enema contains 125 cc. of mineral oil for routine use in softening and lubricating impacted fecal masses. The package is a squeezable container ready for instant use and supplied with a smooth plastic rectal tube for easy administration. **Pharmaseal Laboratories, 1015 Grandview Ave., Glendale 1, Calif.**

For more details circle #554 on mailing card.

Volume Production Cooking With Garland Unit

The new Garland No. 6050 volume cooking unit features a broiler within two ovens. The gas-powered unit has one standard heavy duty controlled type oven above the broiler and in the area under the broiler is another automatically controlled oven. Each oven has a cooking area 26 by 29 inches in size. The fast heating broiler is 26 by 33 inches.

A special feature of the broiler is a

stainless steel mesh installed in the ceramic brick roof to spread the temperature evenly throughout the grid rack. The grid itself is of special design with heavy round bars for free-flowing and ample heat holding capacity. The new broiler is available in Black Japan, stainless steel and the new black porcelain finishes. **Garland Range Division, Welbilt Corp., Maspeth 78, L.I., N.Y.**

For more details circle #555 on mailing card.

Starkote Facing Tile Has Speckle Ceramic Glaze

A new structural facing tile called Starkote features a speckle ceramic glaze which is described as a neutral blue-gray background with gray and blue speckles. Starkote is ideal for walls requiring a high degree of sanitation, minimum maintenance and ease of installation. The body of Starkote is essentially the same in strength and tolerances as previous structural units. **Stark Ceramics, Inc., Canton 1, Ohio.**

For more details circle #556 on mailing card.

(Continued on page 248)

WHAT'S NEW

Pharmaceuticals

Amethone

Amethone Hydrochloride Concentrate is a highly effective topical anesthetic for urological procedures. Amethone (List 3372), administered parenterally for the relief of spasm of smooth muscle, has been deleted from the Abbott catalog. Amethone for urologic anesthesia (New List No. 6890) is chemically identical but should not be confused with the old drug as to its use. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #557 on mailing card.

Viadril

Viadril is a steroid anesthetic for induction of anesthesia before maintenance of patients with nitrous oxide and other inhaled anesthetic agents. Given intravenously, it provides complete relaxation of the larynx and pharynx, induces sleep smoothly and the patient recovers easily from its effects. It is described as particularly satisfactory as a basal anesthetic where the patient is to undergo surgery of the head or neck, where the patient is known to be a poor risk or where a bronchoscope is to be inserted. Viadril is supplied in 100 ml. vials containing 500 mg. of the anesthetic, together with sodium carbonate and sodium chloride. **Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N. Y.**

For more details circle #558 on mailing card.

Estradurin

Estradurin is a new long-acting estrogen developed for use in the treatment of prostatic carcinoma. Its mechanism of action ensures sustained estrogen activity for two to four weeks with a single intramuscular injection, according to the report. Estradurin is packaged in ampule form with sterile diluent. **Ayerst Laboratories, 22 E. 40th St., New York 16.**

For more details circle #559 on mailing card.

Hypaque in Special Compound

The x-ray contrast agent Hypaque is now available in a special compound for use in angiocardiography. Called Hypaque-M, 90%, the compound is described as an effective roentgenologic diagnostic aid in examining heart and thoracic vessels. It is well tolerated by patients who experience few and mild reactions. The new compound may also be used for peripheral arteriography and venography. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #560 on mailing card.

Halotestin

Halotestin is a new, orally effective androgenic-anabolic agent described as being five times more potent than methyltestosterone. The new steroid is indicated in the treatment of protein depletion and testicular hypofunction. It is also useful in the female for control of uterine bleeding, excessive menstrual flow, dysmenorrhea and menopausal symptoms, as well as for palliative therapy in inoperable breast cancer. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #561 on mailing card.

Tempra

Tempra is a new pediatric antipyretic-analgesic for relief of fever and pain. Available in two forms, Tempra Drops and Tempra Syrup, it is designed for convenient and accurate oral administration to infants and children. **Mead Johnson & Company, Evansville 21, Ind.**

For more details circle #562 on mailing card.

Dorbantyl Suspension

Dorbantyl Suspension is the liquid form of Dorbantyl evacuant capsules. Combining the wetting agent dioctyl sodium sulfosuccinate with the peristaltic stimulant Dorbane, the product is described as particularly suited for use in pediatrics, geriatrics and other fields where a liquid evacuant is preferable to capsule medication. It is indicated in the management and treatment of acute or chronic constipation, whether organic or functional, and is effective after surgery, in obstetrical and gynecological cases, and in general medicine. **Schenley Laboratories, Inc., 350 Fifth Ave., New York 1.**

For more details circle #563 on mailing card.

WHAT'S NEW

Literature and Services

• Over 30 new radioactivity measuring instruments introduced recently are described in a new **Catalog of Radioactivity Measuring Instruments** available from Nuclear-Chicago Corp., 229 W. Erie St., Chicago 10. Sections in the catalog deal with scaling units, ratemeters, gamma-ray spectrometer systems, Geiger and scintillation detectors, portable survey instruments for alpha-beta-gamma and neutron measurements, lead shields, personnel protection devices, counting systems, high intensity gamma and beta sources, and nuclear accessories.
For more details circle #564 on mailing card.

• Executone Hospital Communication Systems are discussed in a new booklet, **"Better Patient Care,"** released by Executone Inc., 415 Lexington Ave., New York 17. The audio-visual nurse call system, its components and operating and engineering features, are described, as well as doctors' paging systems, bedside radio-sound systems and hospital intercom systems.
For more details circle #565 on mailing card.

• **"How Clean Is Clean?"** is the title of a new 16mm color sound film available from American Gas Assn., 420 Lexington Ave., New York 17, which explains the proper technics in dishwashing procedures for maximum cleanliness and sanitation. It describes the correct water temperatures for washing and rinsing, demonstrates proper use of equipment and detergent, and correct storage.
For more details circle #566 on mailing card.

• **"New Horizons With Microfilm"** is the title of a new brochure issued by Filmsort Div., Dexter Folder Co., 50 S. Pearl St., Pearl River, N.Y. It describes the Filmsort system of microfilming, details new equipment, supplies and technics for handling records, and provides case history reports on applications, savings and other benefits.
For more details circle #567 on mailing card.

• The **1957 Catalog on Sanymetal Toilet Compartments, Hospital Cubicles and Shower Stalls** has been published by The Sanymetal Products Co., 1693 Urbana Rd., Cleveland 12, Ohio. **Catalog 94** includes a set of color samples, simple mounting diagrams, standard specifications and dimensions, and suggested floor plans.
For more details circle #568 on mailing card.

• How to get maximum efficiency, performance and service from AMF Lowerator Self-Leveling Dispensers is discussed in a new **"Operations Manual"** issued by American Machine & Foundry Co., 261 Madison Ave., New York 16. The booklet is divided into Operation, Maintenance, Heating, Adjustment and Cleaning sections.
For more details circle #569 on mailing card.
(Continued on page 250)

• The complete NCG line of inhalation therapy equipment and accessories is described in a new catalog issued by National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11. Entitled **"Everything for Inhalation Therapy,"** the 24-page booklet covers oxygen tents, masks, resuscitators, nebulizers, humidifiers and gas handling and control equipment.
For more details circle #570 on mailing card.

• The complete line of casters for office and institutional furniture and miscellaneous equipment manufactured by Faultless Caster Corp., Evansville 7, Ind. is described in their new **Catalog 20.** Complete specifications, standard packaging, construction details and selection tables with drawings are included in the 75-page catalog.
For more details circle #571 on mailing card.

• Detailed planning diagrams and dimensional data on installations of Fiat toilet compartments in institutions are included in a new 16-page catalog. **Fiat Compartments Featuring Life-Line Hardware** are the subject of the catalog, stressing their use for toilet room, dressing room and hospital installation. Included in **Catalog No. 570,** available from Fiat Metal Mfg. Co., 9301 W. Belmont Ave., Franklin Park, Ill., is full information on Fiat Junior compartments, entrance and urinal screens, shower dressing stalls and hospital cubicles.
For more details circle #572 on mailing card.

• The use of Barber-Colman automatic electric temperature control systems is described in a new booklet, **"Better Control . . . electrically for Heating and Ventilation systems in Institutional Buildings."** Prepared by Barber-Colman Co., 1300 Rock St., Rockford, Ill., the non-technical booklet discusses the correct application of electric controls, the use of control centers for simple installation and operation and air distribution products.
For more details circle #573 on mailing card.

• **"Vampco Tru-Seal Aluminum Awning Windows"** for institutional and commercial buildings are described in **AIA File No. 16-E.** Specifications, standard window sizes and installation details on the Series 55 window are included, as well as information and diagrams on other series windows manufactured by Valley Metal Products Co., Plainwell, Mich.
For more details circle #574 on mailing card.

• **"Footcandle Levels and Interior Lighting Design Data"** is the title of a technical booklet released by Westinghouse Electric Corp., Lamp Div., Bloomfield, N. J. Data on illumination levels for all types of institutional, commercial and industrial interiors are included. Interior lighting design employing the Lumen Method of Calculation is explained and complete tables for calculation and easy reference are included.
For more details circle #575 on mailing card.

• Tin-lined pipe, fittings, line valves, faucets and accessories, developed especially to protect distilled or demineralized water from metallic contamination, are described in **Bulletin No. 139** prepared by Barnstead Still & Demineralizer Co., 124 Lanesville Terrace, Boston 31, Mass.
For more details circle #576 on mailing card.

• **Davidson Architectural Porcelain** curtain wall panels and facing panels for remodeling or new construction are discussed in a new catalog. Available from Davidson Enamel Products, Inc., 1104 E. Kibby St., Lima, Ohio, the booklet illustrates various construction uses and gives complete diagrams and specifications of various uses to fill individual requirements.
For more details circle #577 on mailing card.

• **"1957 Geyser Wood Bar Windows"** are discussed in a new eight-page bulletin published by E. K. Geyser Co., 915 McArdle Roadway, Pittsburgh 3, Pa. Complete size data and panel diagrams on the windows for either unit openings or continuous fenestration, specifications and standard details are included in the leaflet which carries illustrations of installations.
For more details circle #578 on mailing card.

• **Gleason Standard Casters** for general, commercial and institutional use are discussed in **Catalog No. 412-A** prepared by Gleason Corp., 250 N. 12th St., Milwaukee 3, Wis. Information on how to select the correct caster for the individual job is included.
For more details circle #579 on mailing card.

• **A recipe booklet for fruit pie fillings** using Snow Flake Milo Starch is available from Corn Products Sales Co., 17 Battery Place, New York 4. The booklet is indexed for quick reference in preparing frozen, canned, dried and fresh fruit pies as well as other fillings.
For more details circle #580 on mailing card.

• The new **Benjamin General Catalog No. 28** describes the complete line of lighting equipment for commerce and industry manufactured by Benjamin Electric Mfg Co., Des Plaines, Ill. Complete information on equipment, tables for unit selection and illumination data is contained in the book which is arranged in ten sections labeled with index tabs for easy reference.
For more details circle #581 on mailing card.

Book Announcements

MacEachern, "Hospital Organization and Management," 3rd Ed., 1358 pp., completely rewritten and revised. $18.75. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**
For more details circle #582 on mailing card.

Armstrong, "Aids to Surgical Nursing," 6th Ed., 452 pp., $3.50. Houghton and Sellors, "Aids to Tuberculosis Nursing," 5th Ed., 318 pp., $3. **The Williams & Wilkins Co., Mount Royal & Guilford Aves., Baltimore 2, Md.**
For more details circle #583 on mailing card.

Suppliers' News

Bauer & Black, Division of the Kendall Company, 309 W. Jackson Blvd., Chicago 6, manufacturer of surgical dressings, announces licensing by **Smith & Nephew** of England of the rights to manufacture and distribute **Gypsona Plaster Bandages.** Gypsona, made from a remarkably white and uniform gypsum found in England, produces strong, white casts of dependable uniform quality that have a hard marble finish and are tough but not brittle. The special gypsum will be imported from England but the product will be manufactured in this country by Bauer & Black.

Robert Busse, 64 E. 8th St., New York 3, manufacturer of clinical paper products for hospitals and doctors, announces acquisition of the assets of **ViStep Slipper Co.,** manufacturer of waterproof paper slippers.

Homer Higgs Associates, Inc., 385 Fifth Ave., New York 16, specializing in drug and hospital products, has been appointed exclusive sales representatives for the United States and Canada for the **Dennison Mfg. Co.** line of **Sterilwraps,** the wet-strength crepe paper wrappers designed to meet hospital specifications for wrapping supplies for sterilization. A limited number of distributors will handle hospital sales in the United States.

McGraw-Edison Company, with headquarters in **Elgin, Ill.,** manufacturer of Toastmaster and other food service equipment as well as electrical instruments, batteries, dictating machines and medical gases, announces acquisition of the assets and business of **The Griswold Mfg. Co., Erie, Pa.,** manufacturer of electrical heavy-duty institutional-type cooking equipment. With this acquisition McGraw-Edison now produces a complete line of institutional electrical cooking equipment.

Peck's Products Co., 610 E. Clarence Ave., St. Louis 15, Mo., manufacturer of chemical specialties, announces acquisition of the soap business of **Olin Mathieson Chemical Corp.** The transaction covers sales rights, manufacturing rights, formulas and inventories of specialty soaps formerly made by **Puritan Company** and **Genessee Research Corporation.** Products include liquid surgical soaps and soap concentrates, bactericidal surgical soaps, oil soaps and liquid pine soaps.

Simmons Company, Merchandise Mart, Chicago 54, manufacturer of hospital furniture, announces the establishment of a decorating service for the Contract Department. The newly created **Decorative Department,** with **Mr. Karl L. Steinhauser, A.I.D.,** as Decorating Consultant, will offer a complete decorating service to hospitals, schools, colleges and other institutions.

PRODUCT INFORMATION

Index to "What's New"

Pages 219-250

Key

499 Multifit Control Syringe
Becton, Dickinson & Co.

500 Concealed Door Control
Oscar C. Rixson Co.

501 Intravenous Solution Bottles
Baxter Laboratories, Inc.

502 Blade Dispenser
American Safety Razor Corp.

503 Portable Power Plant
D. W. Onan & Sons Inc.

504 Vina-Lux Flooring
Uvalde Rock Asphalt Co.

505 Suction and Ether Units
Gomco Surgical Mfg. Corp.

506 Stomach and Colon Brushes
Clay-Adams, Inc.

507 Surgical Instrument-Milk
Snowden-Pencer Corp.

508 Double Decanter
Cecilware-Commodore Products Corp.

509 Bulk Oxygen Cradle
Ohio Chemical & Surgical Equipment Co.

510 Town and Country Wagon
Chrysler Corp.

511 Pre-Wrapped Peri-Pack
Johnson & Johnson

512 Food Service Conveyor
Lamson Corp.

513 Scott's Steel Stitch
United Surgical Supplies Co.

514 Floor Machine
S. C. Lawlor Co.

515 Visual Control Panels
Acme Visible Records, Inc.

516 Glide-O-Matic Finishing Unit
The Unipress Co.

517 Viartex Fabrics
L. E. Carpenter & Co.

518 Automatic TeaMaker
Food Machinery & Chemical Corp.

519 Desserts
Ad. Seidel & Son Inc.

520 Cobalt 60 Therapy Unit
The Dick X-Ray Co.

521 Protectol Narcotics Safe
Harold Supply Corp.

522 Automatic Cycling Attachment
V. Ray Bennett & Associates

523 Safety Bathtub Grip
Self Base Units, Inc.

524 Type 505 "Pulsare"
Overseas Service Corp.

525 Traction Frame
DePuy Mfg. Co., Inc.

526 Series "B" Incinerators
Winnen Incinerator Co.

Key

527 Place Setting Kit
Lily-Tulip Cup Corp.

528 Coffee Vending Machine
The Vendo Co.

529 Monitor
Universal Atomics Corp.

530 Fluorescent Unit
Smithcraft Lighting

531 Emergen-Ox
The O.E.M. Corp.

532 Wheel Chair Table
Rehabilitation Products

533 Fresh Orange and Lemonade
Sunkist Growers

534 Plastic Kart-Kover
Samaritan Cart Co.

535 Temperature Monitor
Assembly Products, Inc.

536 Direct Process Masterset
Ditto, Inc.

537 Mobile Book Truck
Brunswick-Balke-Collender Co.

538 Fry-Saver
S. Blickman, Inc.

539 Sierra Flex Receptacles
Sierra Electric Corp.

540 Wall-Mounted Steam Chef
Cleveland Range Co.

541 Portable Dictation Machine
Pelrce Dictation Systems

542 Redesigned Bread Dispenser
Serv-A-Slice Industries

543 Canister Pak for Sodasorb
Dewey & Almy Chemical Co.

544 Recessed Soap Dispenser
Twenty Mule Team Products

545 Plastic Surfacing
Armstrong Cork Co.

546 Liquid Floor Finish
The Penetone Co.

547 Perimeter Seating
The B. L. Marble Chair Co.

548 Wall-Hanging Fountain
Kohler Co.

549 Centriflow Fan Ventilators
Burt Mfg. Co.

550 Korosecl Multi-Link Matting
B. F. Goodrich Co.

551 Thermo-Fax Copying Machine
Minnesota Mining & Mfg. Co.

552 Counter Flex-Seal Cooker
Vischer Products Co.

553 Automatic Defrost System
Foster Refrigerator Corp.

554 Oil Retention Enema
Pharmaseal Laboratories

Key

555 Broiler
Garland Range Div.

556 Starkote Ceramic Tile
Stark Ceramics, Inc.

557 Amethone
Abbott Laboratories

558 Vladril
Charles Pfizer & Co., Inc

559 Estradurin
Ayerst Laboratories

560 Hypaque
Winthrop Laboratories

561 Halotestin
The Upjohn Co.

562 Tempra
Mead Johnson & Co.

563 Dorbantyl Suspension
Schenley Laboratories, I

564 "Radioactivity Instruments"
Nuclear-Chicago Corp.

565 "Better Patient Care"
Executone Inc.

566 "How Clean Is Clean"
American Gas Assn.

567 "Horizons with Microfilm"
Filmsort Div.

568 Catalog
Sanymetal Products Co.

569 Operations Manual
American Machine & Fo

570 "Inhalation Therapy"
National Cylinder Gas C

571 Catalog
Faultless Caster Corp.

572 Catalog
Flat Metal Mfg. Co.

573 "Better Control . . . electrical
Barber-Colman Co.

574 Catalog
Valley Metal Products C

575 Booklet
Westinghouse Electric Co

576 Bulletin
Barnstead Still & Demine

577 Catalog
Davidson Enamel Produc

578 "Wood Bar Windows"
E. K. Geyser Co.

579 Catalog
Gleason Corp.

580 Recipe Booklet
Corn Products Sales Co.

581 General Catalog
Benjamin Electric Mfg. C

582 Book, "Hospital Organization"
Physicians' Record Co.

583 Books
The Williams & Wilkins C

Index to Products Advertised

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—34th Edition

INDEX CONTINUED ON FOLLOWING PAGE

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WHAT'S NEW					ADVERTISEMENTS												
499	500	501	502	503	584	585	586	587	588	589	590	591	592	593	594	595	596
504	505	506	507	508	597	598	599	600	601	602	603	604	605	606	607	608	609
509	510	511	512	513	610	611	612	613	614	615	616	617	618	619	620	621	622
514	515	516	517	518	623	624	625	626	627	628	629	630	631	632	633	634	635
519	520	521	522	523	636	637	638	639	640	641	642	643	644	645	646	647	648
524	525	526	527	528	649	650	651	652	653	654	655	656	657	658	659	660	661
529	530	531	532	533	662	663	664	665	666	667	668	669	670	671	672	673	674
534	535	536	537	538	675	676	677	678	679	680	681	682	683	684	685	686	687
539	540	541	542	543	688	689	690	691	692	693	694	695	696	697	698	699	700
544	545	546	547	548	701	702	703	704	705	706	707	708	709	710	711	712	713
549	550	551	552	553	714	715	716	717	718	719	720	721	722	723	724	725	726
554	555	556	557	558	727	728	729	730	731	732	733	734	735	736	737	738	739
559	560	561	562	563	740	741	742	743	744	745	746	747	748	749	750	751	752
564	565	566	567	568	753	754	755	756	757	758	759	760	761	762	763	764	765
569	570	571	572	573	766	767	768	769	770	771	772	773	774	775	776	777	778
574	575	576	577	578	779	780	781	782	783	784	785	786	787	788	789	790	791
579	580	581	582	583	792	793	794	795	796	797	798	799	800				

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499 500 501 502 503 | 584 585 586 587 588 589 590 591 592 593 594 595 596
504 505 506 507 508 | 597 598 599 600 601 602 603 604 605 606 607 608 609
509 510 511 512 513 | 610 611 612 613 614 615 616 617 618 619 620 621 622
514 515 516 517 518 | 623 624 625 626 627 628 629 630 631 632 633 634 635
519 520 521 522 523 | 636 637 638 639 640 641 642 643 644 645 646 647 648
524 525 526 527 528 | 649 650 651 652 653 654 655 656 657 658 659 660 661
529 530 531 532 533 | 662 663 664 665 666 667 668 669 670 671 672 673 674
534 535 536 537 538 | 675 676 677 678 679 680 681 682 683 684 685 686 687
539 540 541 542 543 | 688 689 690 691 692 693 694 695 696 697 698 699 700
544 545 546 547 548 | 701 702 703 704 705 706 707 708 709 710 711 712 713
549 550 551 552 553 | 714 715 716 717 718 719 720 721 722 723 724 725 726
554 555 556 557 558 | 727 728 729 730 731 732 733 734 735 736 737 738 739
559 560 561 562 563 | 740 741 742 743 744 745 746 747 748 749 750 751 752
564 565 566 567 568 | 753 754 755 756 757 758 759 760 761 762 763 764 765
569 570 571 572 573 | 766 767 768 769 770 771 772 773 774 775 776 777 778
574 575 576 577 578 | 779 780 781 782 783 784 785 786 787 788 789 790 791
579 580 581 582 583 | 792 793 794 795 796 797 798 799 800

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606 American S
607 Ames Comp
608 Anemostat
609 Anaco Corp
610 Appleton E
611 Armour & C
612 Armstrong
Gordon
613 Automatic
614 Ayerst Labo
615 Barber-Colm
616 Bard-Parker
617 Barnstead S
(HPF) ....
618 Bassick Con
600 Baxter Labo
601 Baxter Labo
619 Bay West P
620 Beam Metal
621 Becton, Dick
(HPF).....
622 Blickman, In
623 Brewer Com
624 Brillo Mfg.
625 Brown Comp
626 Buda Divisio
627 Burroughs C
628 Carolina Ab
629 Carrier Corp
630 Carrom Indu
631 Castle Comp
632 Caterpillar T
633 Ceco Steel P
634 Central State
635 Clarke Sandi
(HPF) ....
636 Classified Ad
637 Clay-Adams
638 Coca-Cola Co
639 Collins, Inc.,
640 Colson Corpo
641 Continental
642 Crane Compo
643 Crescent Surg
644 Darnell Corp
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Division
647 Diack Contro
648 Diamond Cry
649 Dixie Cup Co
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654 Du Kane Cor
655 Duke Mfg. Co
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